National Assembly for Wales
Finance Committee

The Cost of Caring for an Ageing Population
Consultation Responses

March 2018

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CCAP 03*	Gofal Cymdeithasol Cymru	Social Care Wales
CCAP 04	Coleg Brenhinol Meddyginiaeth Frys Cymru	Royal College of Emergency Medicine Wales
CCAP 05	Cymdeithas Iechyd Sosialaidd Cymru	Socialist Health Association Wales
CCAP 06	RNIB Cymru	RNIB Cymru
CCAP 07	Cymdeithas Alzheimer's Cymru	Alzheimer's Society Cymru
CCAP 08	Unigolyn – Mrs X	Individual – Mrs X
CCAP 09	Cartref Gofal Cristnogol Florence Justice	Florence Justice Christian Residential Home
CCAP 10	National Community Hearing Association (NCHA)	National Community Hearing Association (NCHA)
CCAP 11	Cynghrair Henoed Cymru	Age Alliance Wales
CCAP 12	Cymdeithas Ddeieteteg Prydain	British Dietetic Association
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CCAP 16	Gwasanaethau Cymdeithasol Cyngor Caerdydd	Cardiff Council Social Services
CCAP 17	Gwasanaethau Cyhoeddus Cymru 2025	Wales Public Services 2025
CCAP 18	Fforwm Gofal Cymru	Care Forum Wales
CCAP 19	Age Cymru	Age Cymru

CCAP 20	Unison Cymru	Unison Wales
CCAP 21*	Cymdeithas Llywodraeth Leol Cymru / Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru	Welsh Local Government Association / Association of Directors of Social Services Cymru
CCAP 22	Gofal a Thrwsio Cymru	Care and Repair Cymru
CCAP 23	Ymddiriedolaeth Gofalwyr Cymru	Carers Trust Wales
CCAP 24	Conffederasiwn GIG Cymru	Welsh NHS Confederation

Strategic Review of the Care Sector in Flintshire

November 2017

Cyngor Sir y Fflint
Flintshire
County Council

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1 Introduction

Social Services are delivered within a context of rapidly changing social, demographic and environmental demands, and the department needs to be able to respond to those demands whilst at the same time continuing to meet the needs of its service users and their carers within a limited budget, whilst aligning practice to the Social Services and Well-being (Wales) Act 2014.

Many of our external providers (domiciliary, nursing and residential homes supporting elders and people living with dementia) are facing huge pressures and are concerned about the sustainability of their businesses.

In order to support the local sector, Flintshire County Council agreed to fund a 12 month post looking at the key factors that are influencing the fragility of the care sector in Flintshire in depth and develop a programme plan in line with priority areas to work on to address these factors. The project will also support the political argument being made in Flintshire regarding the fragility of the sector and help us to address some of the pressing issues providers and commissioners are raising. This report is the result of that work.

The work has been overseen by a Steering Group made up of providers from the sector, officers within the Council and Third Sector representatives, who's knowledge and experience have been invaluable in the development and implementation of some of the work streams. We have also engaged with the wider sector though provider meetings.

Some of the issues affecting the sector are well documented, but a brief overview of each will be included here for context. Several useful documents are available, which have been reviewed alongside this work and may be referenced in other chapters. Some useful regional and national sources of information are outlined below.

Useful sources of information – Regional and National Reports

North Wales Population Assessment (2017)
This report is an assessment of the care and support needs of the population in North Wales, including the support needs of carers. It has been produced by the six North Wales councils and Betsi Cadwaladr University Health Board (BCUHB) supported by Public Health Wales, to meet the requirements of the Social Services and Wellbeing Act (Wales) 2014 (the Act).

The report aims to improve our understanding of our population and how it might change over the coming years to help us provide better public services in North Wales. To prepare the report we looked at statistics, spoke with our communities and made use of a wide range of information collected by local councils, health services, charities and other organisations that provide services.
http://www.flintshire.gov.uk/en/PDFFiles/Social-Services/Population-assessment/NW-Population-Assessment-1-April-2017.pdf

'Above and Beyond' – National review of Domiciliary Care in Wales (2016)

This report sets out the findings of the national review of care provided to adults in their homes (domiciliary care) carried out by Care and Social Services Inspectorate Wales (CSSIW) between August 2015 and March 2016.
http://cssiw.org.uk/docs/cssiw/report/161027aboveandbeyonden.pdf

Development of a strategic plan for care and support at home Literature review (SCIE, 2016) - This document provides detail drawn from 'research, policy and practice literature' to summarise the 'themes around domiciliary care workforce, person-centred, relationship-based care, outcomes-focused services, specialist services, integrated care, commissioning, and characteristics of the home care market'. This document was prepared to support the 5 year strategic plan for Care and Support at Home 2017-2022
https://socialcare.wales/cms_assets/file-uploads/Care-and-support-at-home-in-Wales-Literature-review.pdf

Care and support at home in Wales - Five-year strategic plan 2017-2022 (Social Care Wales, 2017)
The plan considers a wide range of evidence including reviews, reports and research. It gives a strong voice to people who need care and support, carers who need support and the workforce.
https://socialcare.wales/resources/care-and-support-at-home-in-wales-a-summary-of-the-five-year-strategic-plan-2017-2022-1

Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact on the quality of domiciliary care (Atkinson et al, 2016).
The Welsh Government and the Care Council for Wales commissioned this research with the overall aim of exploring the factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care

The findings from the research have informed a public consultation on policy interventions to improve the quality of domiciliary care through positively impacting on the recruitment and retention of domiciliary care workers
http://gov.wales/statistics-and-research/factors-affect-recruitment-retention-domiciliary-care-workers/?lang=en

The Care Home Market in Wales: Mapping the Sector (Moultrie and Rattle, 2015) IPC
An overview of the care home market for older people in Wales and a view on its future sustainability. The project has involved analysis of quantitative and qualitative data.
https://sites.cardiff.ac.uk/ppiw/files/2015/11/The-Care-Home-Market-in-Wales-mapping-the-sector.pdf

Parliamentary Review of Health and Social Care in Wales – Interim Report (Welsh Government, 2017)
In November 2016, Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport announced, with cross party support, an independent review into the future of health and social care in Wales by an international panel of experts.

This interim report sets out the case for change and initial findings. The final report and recommendations will be submitted to the Cabinet Secretary by the end of 2017.

Ageing in the UK Now: A snapshot of current research (Beth Johnson Foundation, 2017)
The overall aim for the review was to provide research support to the development of the Beth Johnston Foundation's strategy. In pursuit of these objectives, a scoping exercise, outlining the key present areas of research relevant to the UK's ageing sector, and mapping of these against the wider political agendas in society, was produced. This final summary report identifies the areas where organisations within the ageing field can make a significant impact, and understand where future initiatives might be focused.

One of the key principles behind this work however, is that a solution developed for one provider or community may not be appropriate to another. We must consider multi-stranded approaches to this work and focus on the principles of co-production to ensure that work undertake in the future is done so in partnership with the sector, key stakeholders and citizens.

"Instead of developing 1 solution you may use 100,000 times, develop 100,000 solutions you may use once'.
Anon

1.1 The Older People's Population of Flintshire
The population of older people in Wales grew by 77,176 people between 2009-10 - 16 and formed 20.2% of its population in mid-2015. A 2016 OECD (Organisation for Economic Co-operation and Development) report confirms that although the burden of chronic and complex conditions associated with increased life expectancy is increasing across the UK, it is higher in Wales than England.

Another key indicator, the levels of poverty (linked with ill health), is also higher in Wales than the other UK countries. On current population projections, Wales would need to be spending at least an additional £129 million by 2020-21 (at 2016-17 prices) to bring the per capita spend on local authority social services for over-65s back to 2009-10 levels (Luchinskaya, 2017).

Flintshire's older population (+80) is predicted to rise by 23% by 2020, with the number of older people with significant health and social care needs predicted to rise by 22% during the same period (Flintshire County Council, 2016). The Welsh Government's Future Trends (2017) report predicts that if current rates persist, there will be an increase in dementia sufferers across Wales. By 2025 there could be '50,000 people aged 65 or over living with dementia in Wales, with nearly a quarter of them aged 90 or over'. The North Wales Population Needs Assessment (2017) states from the data available, the number of people living with dementia in North Wales is between 4,600 and 11,000 and that this figure is anticipated to rise with approximately 3,700 people living with dementia in Flintshire alone by 2030.

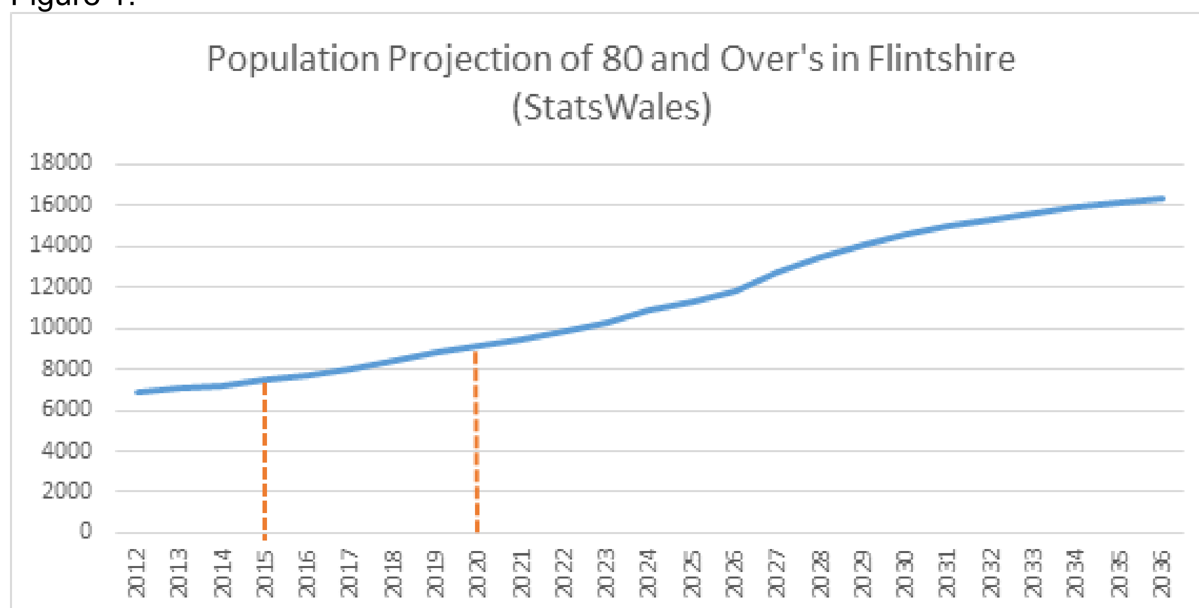
Table 1: Number of people aged over 65, population projections 2014 to 2039

	2014	2019	2024	2029	2034	2039
Anglesey	17,000	18,000	20,000	21,000	22,000	23,000
Gwynedd	27,000	29,000	31,000	33,000	35,000	35,000
Conwy	30,000	33,000	35,000	38,000	41,000	42,000
Denbighshire	22,000	23,000	25,000	27,000	29,000	30,000
Flintshire	30,000	34,000	37,000	40,000	44,000	46,000
Wrexham	25,000	28,000	30,000	33,000	36,000	39,000
North Wales	150,000	170,000	180,000	190,000	210,000	210,000

Numbers have been rounded so may not sum

Source: 2014-based population projections, Welsh Government within North Wales Population Needs Assessment (2017)

Figure 1:



Source: Flintshire County Council, 2016

Before exploring the issues faced by providers of care, it is important to spend some time looking at the factors affecting health and well-being and what older people feel is important to them as they get older.

If we are to look in a preventative way as part of this work, we must not constrain ourselves by looking for solutions within the social care sector alone, and look at the broader range of resources and partners available. As part of this work, consideration will be given to how we can work with others to meet the changing needs of our aging population, the workforce and local providers.

Flintshire County Council has developed a local Ageing Well Plan. This action plan begins to outline the work to take place in Flintshire over the next five years against each of the five national priority areas, which are:

- Age-Friendly Communities
- Falls Prevention
- Dementia Supportive Communities
- Opportunities for Learning and Employment
- Loneliness and Isolation

Loneliness and isolation presents a significant challenge for people as they get older. The Welsh Government's Ageing Well in Wales Programme (NWPNA, 2017) goes on to say that 'having strong social networks of family and friends and having a sense of belonging to the local community is important in order to reduce social isolation and loneliness for people who need care and support and carers who need support'.

Research suggests that loneliness and isolation have significant effects on the mental and physical health of people in our communities and has been likened to smoking 15 cigarettes a day (Holt-Lunstad, 2015 via Campaign to End Loneliness). By putting in measures to tackle this issue, the need for social care services may be reduced.

The assets available in a person's community are just as important as the care they received at home or within a residential care setting for maintaining health and wellbeing. Through consultation in local communities to gather information for the local Ageing Well Plan, older people who attend 50+ Action Groups identified a number of factors that would contribute towards an 'age friendly' community. Older people expressed concern over access to transport and social activities alongside feeling safe in their community.

"Getting out is important, otherwise you can become isolated".

Flintshire County Council is committed to supporting people with dementia. In partnership with NEWCIS, the Council employs an officer to lead on the development of Dementia Friendly Communities, intergenerational projects, Memory Café's, research and programmes aimed at supporting people living with dementia.

This successful partnership working has created:

- 9 memory Cafes
- Dementia Friendly Communities (Mold, Buckley, Flint)

- 4 Steering groups ready for the next steps
- 44 Dementia Friendly businesses and organisation and more on the way
- 7 Dementia Friends Schools with 2 more on the way
- 16 Care Homes working together

1.2 Funding Pressures

In Flintshire, the Social Services portfolio total budget figures for 2016/17 are:-

Net budget	£60,551m
Income budget	£13.782m
Gross expenditure budget	£74.333m

The Welsh Local Government Association which represents councils, has called upon the Welsh Government to 'recognise and address the immediate funding pressures facing the social care sector' (WLGA, 2016) and to invest more in the preventative services as the 'sustainability of the NHS is intertwined with the sustainability of other public services, most crucially social care'.

If costs in Wales rose in line with the projections for England, there would be an increase in net local government spending on social care for older people of around 55 per cent by 2025, with a further large increase in the five years to 2030 taking the total increase to 101 per cent. There would be an increase in local authority net expenditure from £510 million in 2010-11 to around £794 million in 2025 (Wales Public Services 2025, 2016).

In 2016/17, the total net spend on purchased domiciliary care for older people was £6,051,176 which was made up of the following elements:

Payment to external care providers	£5,202,484
Direct payments	£1,154,960
Income*	(£306,268)
Total:	£6,051,176

In 2016/17, the total net spend on purchased residential and nursing care for older people was £5,747,368 which was made up of the following elements:

Residential Care Payments	£5,257,863
Nursing Care Payments	£2,572,198
Income**	(£2,082,693)
Total:	£5,747,368

*The income is made up of a mixture of joint funding contributions from BCUHB, service user contributions, and recoupments of over payments in relation to direct payments. There is also a recharge of £53,053 to BCUHB in respect of their contribution to our costs of supporting service users with early on set dementia.

** The income covers £500k from ICF towards the cost of residential care, £535k Free Nursing Care from BCU, £25k BCU CHC, £141k Client Contributions, £859k Property Income.

Some innovative solutions have been suggested. Gerald Holtham, Hodge Professor of Regional Economics, has written a paper making a case for the Welsh public to contribute towards their care in old age through a levy (Holtham, 2017). The author is meeting with Mark Drakeford at Welsh Government to discuss the proposal, however, any introduction of a proposal of this kind will be a long and complex process.

At a recent King's Fund event Geoff Huggins, Director of Health and Social Care Integrations from Scottish Government also outlined that £250m of their £400m budget for health is spent on social care services. Scotland spend more per head on social care out of the four UK countries. Further lessons could be learnt from this approach.

2 Factors Affecting Care Providers

Between June and September 2017, Osterley Associates offered a business diagnostic to providers across the residential and nursing sectors who were based within Flintshire on behalf of the Council. Osterly Associates is an independent consultancy which was established in 2014 to provide business sustainability support to community based businesses and stakeholders. It specialises in working with SMEs in groups and sectors that are vulnerable to political change or facing challenges that are outside normal business modelling. Often the businesses in these groups are micro or family run and as such do not access mainstream support.

Owners and managers from 18 homes were interviewed by an experienced business adviser and a diagnostic review was completed, 2 homes declined the offer and 4 were unable to schedule an interview in the timescale.

The diagnostic tool to conduct the interviews was designed to structure the interview but allow for a personal conversation so as to ensure that individual circumstances were accommodated (Osterly Associates, 2017).

Summary Findings of the Business Diagnostics

General description of business
The group owned care homes were able to provide varying degrees of back of house support and many administrative tasks were conducted on a central basis. This allowed the registered manager to concentrate more on the delivery of care than worrying about the day to viability of the business.

Smaller independent homes were more reliant on the capability of the registered manager and time pressures and work load were more noticeable in these homes.

Client/Patient Base
The differing factors between private and Local Authority (LA) sponsored patients were investigated and at no time was any discrimination noted in valuing patients. Because of financial pressures most of the homes are now requesting top up fees from LA sponsored patients. The business advisers observed care and innovative

methods adopted by the homes to care for the patients. The level of activities with the patients were high, the care assistants were engaged with the patients and communication between the managers and staff appeared to be positive.

Staff
The availability of local transport has an impact on some of the homes and those on good bus routes were more likely to be able to staff their homes than those off a main bus route. All of the homes interviewed paid at or above the living wage but recognised that this would be difficult in the future as wages increase above the income streams. Group owned homes had central HR services available to them and several of the family owned homes contracted with external HR agencies such as Peninsula to manage their HR issues.

Sickness and absence rates are high in comparison to other industries but it is accepted as one of the negatives of the sector. The most common causes of absence is sickness and diarrhoea. The impact is for a short term need to replace staff and the added costs associated with this. All homes operated a statutory sickness policies.

When asked directly about the difficulties of recruiting staff there was a variance in replies. Several homes stated that more should be done to increase the image of the sector and that very often potential recruits were unaware and unprepared for the nature of the job. The variation in replies came when some homes stated that they had difficulty in finding suitable candidates and others stated that they had waiting lists. Others suggested that the NHS “poached” the experienced members of staff and several homes were proud of the fact that majority of their staff had been employed by them for many years. It was concluded that the difference is likely to be effected by the size of the home and the way that the home is managed. The fact is that there is a need to attract new entrants into the sector and increases in the living wage will add to the financial pressures on owners in the future.

Training
All homes visited were very proud of their training record and acknowledged the value of the Flintshire County Council training vouchers. The homes owned by a group have their own training programmes in place and often used external training providers. They recognise the value of career progression and remarked that this policy often assisted in staff retention rates. Smaller family owned homes found the cost element to be more of a handicap but still recognised the need. There was a willingness for managers to broaden their management skills but stated that time to train was a major barrier in them not proceeding.

Premises
Many homes are converted Victorian merchant houses or country homes and several had recently expanded the premises. Many are old and difficult to alter. Many of the older buildings are not energy efficient and the ability to meet the new care standards is beginning to take effect. One home interviewed had a genuine concern about the prospect of having to decommission 4 rooms which would reduce their income by £100,000 per annum. Others spoke about the cost of heating the buildings with one example of a monthly oil bill of £1,400. Other

businesses have used as much of the outside space as practical thus restricting future growth. Homes that are located in an urban area tended to be restricted for future expansion and in the sample we visited, there seemed little capacity for new growth. However, homes located in more rural Flintshire have significant space, excellent outside space but are less convenient to access.

Sales and Marketing
When asked "What is the breakeven figure for the number of patient's resident in the home to make the business viable?" No home could answer this. However, they were fully aware as to whether they were losing money or not. Almost all of the homes were fully occupied and several had waiting lists for rooms. This negated the need to advertise the homes to attract residents.

Asset Management
A recent grant from Flintshire County Council for asset purchase has had a significant effect on the sector and was broadly welcomed by all homes. There is a general acceptance that a good standard of assets is an important part of providing a quality service and all homes stated that they regularly review and upgrade assets. A common comment amongst all homes was the wish that an asset library be established where equipment that is expensive to purchase and only used on occasion could be sourced and a rental scheme for larger equipment be considered.

Environmental and Energy. The cost of utilities was highlighted as an issue and there was a distinct difference between group owned and privately owned homes. The group owned homes had a central utilities policy and the purchasing decisions were not made by the registered manager, but the privately-owned homes were very conscious of the cost implications. Heating costs were the biggest concern and many of the businesses had signs of being very inefficient. Several homes suggested that they would be interested in a joint procurement project to give themselves a stronger buying power. The value of a robust Waste policy is an area that is becoming more topical and most homes indicated that if we were able to provide support in this area, it would be welcomed.

Finance
All of the homes are reporting that the financial viability of the business is getting more challenging. The majority of the homes require a top up to LA sponsored fees and need a proportion of private patients to survive. The impact of the new care standards will add to cost in the short term but the biggest threat to the sector will be the cost of employing suitable staff. The increase in the living wage, a general reduction in unemployment rates, increase in employment and the unknown impact of Brexit suggests that the pool of candidates will get smaller. Profit margins are tight and any increase in interest rates plus increases in other overheads such as business rates, fuel costs and food costs will have an impact on the long term sustainability of the sector.

Compliance
The new care standards are very much at the forefront of planning for all of the homes. Each home had their own needs to address on compliance, but they have

accepted that the intention of the care standard is for “increasing standards”, and have prioritised these issues.

Growth
Many of the homes have either recently increased their capacity or are intending to increase their capability. There is limited opportunity for some of the homes visited to extend due to restricted outside space and one home is for sale, so there are no plans for growth. Several of the privately owned homes indicated that they would be prepared to meet a growth adviser in the future.

The feedback received has mainly focused on the issue of recruitment and retention in the sector and the purchase of consumables, utilities, equipment and waste services.

Recruitment and retention issues are reported as the most significant issue affecting the sector locally. However, providers have identified that people in the workforce don’t necessarily leave the sector, but move around within it and when they do leave, move on to employment in other caring roles such as within the NHS. Our challenge is to increase the number of people entering the sector.

There are difficulties here. Colleagues at Job Centre Plus report that they are not encountering many who are seeking work in the sector, and those who have expressed an interest are looking for ‘9-5’ hours, which is not conducive with working patterns in care. Provider assistance has also been removed in recent years, including apprenticeships funding for people aged over 25 leading to difficulties in staff gaining the relevant qualifications or staff having to pay the fees themselves leading to providers finding it difficult to meet the current requirement that 50% of staff to be qualified to QCF level 2, unless they support with funding the training themselves.

Further changes affecting recruitment and retention in the sector are expected with the implementation of the regulations of the Regulation & Inspection of Social Care (Wales) Act 2016.

The recently drafted North Wales Care and Community Health Workforce Strategy outlines that in 2016 surveys showed that 38% of domiciliary care workers and 36% of the residential care are unqualified. This is a significant number of workers that will need training in order to meet the new registration requirements, with increased resource implications for the sector. Concerns have been raised about the number of assessors available to meet the increased demand, which may have implications on provider’s ability to comply with regulations.

A review in to Flintshire’s Residential Care sector (2016) outlines the challenges and some potential options as we move forward, but highlights a number of strategic issues that ‘would impede efforts by any local authority to strengthen their residential care market’. National coordination and action will be needed to minimise the impact of these factors, which include:

1. The effect of the National Living Wage on the sustainability of independent care providers.
2. Reported lack of financial resources available to improve the state of repair of independent care homes, and a decreasing appeal for potential new investors to the sector.
3. Retention and recruitment rates of care staff, with a perceived unclear career pathway and unappealing job conditions, specifically registered managers.
4. A national concern of poorly performing nursing homes.
5. Increasing demand for services with decreasing budgets'.
6. Brexit

On a local level, Flintshire have been working in partnership with providers and others to support local providers and transform commissioning and provision of care. Flintshire are embedding "Creating a Place Called Home – Delivering What Matters" to deliver 'very best experience we can imagine for an older person living in a care home in Flintshire. Using person-centred practices we want to better enable people to make choices and have more control over how they live their lives' (Flintshire County Council, 2017).

As part of this, Flintshire, have developed the 'Progress for Providers' Programme in Care Homes. This is a self-assessment tool for managers to use with their staff to check how they are doing in delivering personalised support for people living in care homes, tailoring support to the individual and enabling them to have as much choice and control over their service and life as possible. Using person-centred thinking tools and approaches helps staff to provide the best support that they can in ways that reflects what is important to the person.

Bronze, Silver and Gold accreditation will help managers check their own progress over time and demonstrate publically that they are making continued progress along the road to truly person centred care. Those who have achieved the accreditation will be listed on Flintshire County Council's website.
Further issues include those centred around the workforce within homes. Shortages in nursing staff are presenting a problem across the UK (Public Policy Institute for Wales, 2015). In 2017, Welsh Government began to consult on the Phase 2 regulations for the Regulation & Inspection Act Wales 2016. Within this, a proposal was outlined that there would no longer need to be 24 hour nursing care on site for as long as it can be proven that the provision meets the needs of the individual. This may have an impact on those setting who have a low need for nursing care, as they can look at how they can meet these needs in a more flexible way. However, for homes where high levels of nursing care are required, the issue is still present.

Much has been written on the issues surrounding recruitment and selection in the Domiciliary Care workforce. In March 2016, Welsh Government published a research report on the 'Factors that affect the recruitment and retention of domiciliary care

workers and the extent to which these factors impact upon the quality of domiciliary care' (Atkinson et al, 2016). The research, undertaken by Manchester Metropolitan University sought to identify factors that influence whether people choose to 'become and remain working as domiciliary care workers'.

There are approximately 15,000 domiciliary care staff employed by commissioned care providers in Wales (Care Council for Wales, 2015). Welsh Government's consultation in to the Domiciliary Workforce (2016) recommends that those working in the sector are recognised as the skilled professionals they are. The negative image of the sector must be challenged to encourage people to join the social care workforce.

The key factor highlighted by this consultation included:

- Low wages
- Work pressures
- Unsociable hours
- Poor terms and conditions
- 'Zero hours' or 'non-guaranteed hours' contracts deterring people from joining the sector, as there were no guaranteed hours
- Some call times not enough to address the needs of the individual
- Lack of training and career development opportunities
- Seen as a low status job compared to healthcare

The Phase 2 consultation on the draft regulations for the Regulation & Inspection of Social Care (Wales) Act 2016 took place during summer 2017. The consultation included limiting the use of non-guaranteed hours contracts; the delineation of care time and travel time; and extending the Social Care Wales register of Social Care Workers to include domiciliary support workers. This workforce-related consultation also invited stakeholders to explore solutions to the current shortage of registered social care managers in Wales. An event hosted by the Council in August with Domiciliary Care providers enabled them to discuss these elements and feed them in to the Council's response. In addition to this, consultation also took place on the fees required for registration and the qualification requirements by Social Care Wales though 'Transforming Care in the 21st Century'.

The feedback received raised a number of areas of concern, which have been fed back to Welsh Government and Social Care Wales. These centred around the additional requirements for registration, paying the registration fee and the need for a social care workers to achieve a certain level of qualifications. These all have a negative impact on the sector which is already struggling to recruit and retain staff. In addition to this, gaining the qualifications needed to register may be prohibitive to older staff, who may then leave a void of good, experienced staff. This has led to fears in some providers that the quality of care will be in jeopardy.

Moving forward, we must be mindful of the quick pace of change within the sector on a national and local level. Alongside the changes in legislation, North Wales will be moving towards a regional framework for the commissioning of domiciliary care. This is described in section 4.

3 Support for Local Providers

Over the years, Flintshire have been working to develop strong relationships with those who provide services for Flintshire's residents. The Council support providers in a number of ways.

- Regular Provider Meetings, open to all care providers in Flintshire, which include updates, Care Forum representative feedback, workshops and information sharing. These events are valued and enable two way communication between provides and the Local Authority. These events are also used to develop a coordinated response to national consultations. The Local Authority can then submit responses that includes the voice of the local sector alongside our own.
- Information is circulated on a regular basis to providers via email.
- Training is available via the Council's Workforce Development Team and number of providers attend the Workforce Strategy Meeting.
- Providers are supported to achieve accreditation through Progress for Providers Programme.
- The Council has developed a template for providers to produce a 'Welcome Pack' for new residents. The pack, tailored to each home, outlines information on rights and entitlements, staff, what's available locally and person-centred practices.
- The Contracts Monitoring Team provide support for settings who may be facing difficulties or in need of improvement.
- Through the Council's dementia work, free activities are provided to care homes via a 'buy one get one free' as part of the Dementia Friendly Communities programme, coordinated through a private Facebook group.
- Providers are offered support with National Care Home Open Day.
- Flintshire County Council provided equipment packs containing hoists, a mattress, chair, commode, bath lift, scales and other equipment to all care homes in 2017.
- The Social Care Workforce Development Programme (SCWDP) training voucher scheme gives independent and voluntary sector social care staff access to mandatory or core training from a small number of approved local training providers.

4 Regional Work Streams

Alongside the work undertaken on a local level to support providers, it is important to take in to consideration and support the work taking place on a regional basis.

North Wales Workforce Strategy - A draft strategy has been developed and an event was held on 21/02/17 for partners to look at the priority areas. Further work will be undertaken as a result before the next version is shared.

- Stabilising the workforce
- Learning and development
- Workforce intelligence and planning

- Changes in the way we deliver services

Social Care Wales is also in the process of putting a framework focusing on recruitment, retention and careers across the whole of the Social Care Wales footprint.

Social Value Forum – A Steering group has been established to support the development of not-for profit organisations to meet the duty placed on Local Authorities under Part 2, section 16 of the Social Services and Wellbeing (Wales) Act 2014 and to maximise social value and coproduction in providers delivering health, social care and wellbeing services. The group is looking at how social value can be measured and quantified and the development of Social Value Forums on a local level. Locally, Flintshire County Council are developing Community Benefits Strategy and a list of emerging economic, environmental, health and social 'Community Benefits', which support the reduction in demand on public services.

North Wales Domiciliary Care Framework - The way domiciliary care and support is being commissioned will fundamentally change with the introduction of the Framework. This project will evaluate the quality of registered domiciliary care providers (or companies that have submitted an application for registration) using MEAT criteria (most economically advantageous tender – in terms of price, quality and social value). Successful bidders will be awarded an agreement to provide domiciliary care services in North Wales and will be ranked by overall score. Fundamentally, this will move commissioning away from task and time basis to a more outcomes focused approach.

It is hoped that the work and successes in the Progress for Providers work will be repeated in the domiciliary care sector as elements of this programme will be included in the Framework.

In readiness for the change, officers have been keeping providers updated on changes via email and quarterly provider events. Officers are also linked with Business Wales who will be able to provide independent support to providers to access the Proactis Portal and to support the process.

The anticipated timescale for this 3 phase project is as follows (subject to change):

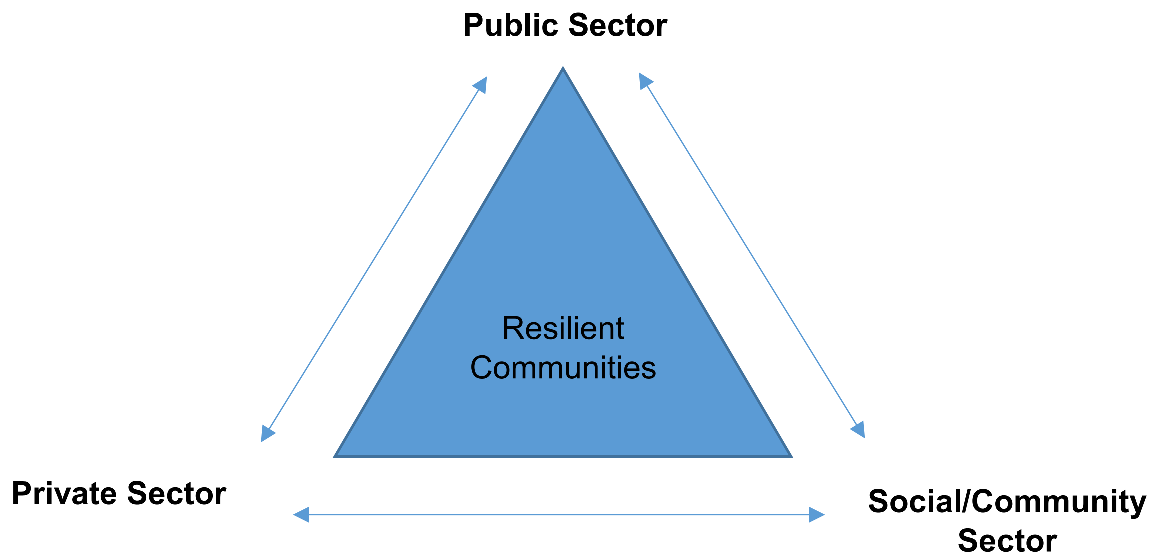
- Standard domiciliary care tender from August - October 2017, with award in early 2018 and commencement from April 2018
- Enhanced domiciliary care tender from Jan – March 2018, with award and commencement in summer 2018
- Supported Living tender from September – November 2018, with award and commencement in summer early 2019

A further 'meet the buyers' event is scheduled for October 2017.

5 Community Based Approaches

Community based approaches play a key role in keeping people living independently for longer which may reduce, delay or prevent the need for formal social care. These may be delivered by a number of partners, including the Third Sector, private sector and Local Authority. These approaches put people at the heart of the work, and focuses on what matters to the individual and the community.

Figure 2: Resilient Communities Model – Supported by all sectors.



The Flintshire Public Services Board are implementing an 'Inspiring Resilient Communities Framework'. High levels of resilience enable communities to prosper and thrive and supports individuals to fulfil their potential. This leads to a reduction in demand for public services. The framework recognises that community based work is essential if communities are to be engaged and empowered to solve the issues they face and that any approach has to be 'co-designed with communities and partners, and has to evolve and adapt based upon the results and learning' (Flintshire Public Services Board, 2017).

Local examples of community approaches:

Positive Steps - The British Red Cross and Royal Voluntary Service are also delivering a new project called Positive Steps / Camau Cadarn project. This project supports people aged 50+ who are experiencing loneliness or need support to access resources in the community. This will include intensive reablement support, and longer term volunteer-led support.

Community Agents - Wrexham County Borough Council have commissioned AVOW to coordinate their Community Agents. The Community Agents are managed by Community Councils. Community Agents can tap into third sector services around the county to support people in their community. GPs are linking people in to the Community Agents.

Community Navigators –Community Navigators also operate in Denbighshire through the Red Cross. Navigators are employed to go attend ‘Talking Points’ based around the county to enable citizens to have an opportunity to meet with someone who is knowledgeable about what’s available in the community. By 1st March 2017, the team reported 369 citizens were prevented from being referred to Social Services.

Age Friendly Communities - The Ageing Well in Flintshire Action Plan identifies what needs to be done and by whom, to make growing older in Flintshire a good place to be.

Men’s Sheds – The national UK Men’s Sheds Association a place for men where they can share the tools and resources they need to work on projects of their own choosing at their own pace and in a safe, friendly and inclusive venue. They are places of skill-sharing and informal learning, of individual pursuits and community projects, of purpose, achievement and social interaction. A local men’s shed operate in Denbigh.

Social prescribing – Between October 2015 and July 2016, Social Prescribing project was a collaboration between Clarence House Surgery, Communities First (Co-op Group) and the British Red Cross. The British Red Cross were asked to pilot a project which could support individuals to find solutions to their concerns which were community based and more relevant to their needs. Those referred in were supported through visits and phone calls to access or be signposted to a wide range of organisations in the community.

A short term project to establish proof of concept for social prescribing is also being run by FLVC on behalf of the Health Board.

Befriending Services - The Red Cross Gofal Telephone Befriending Service North Wales aims to alleviate isolation and loneliness and encourage social interaction and emotional wellbeing. Trained volunteers telephone the service user every week for a friendly chat, to offer companionship, support and a listening ear. Where possible the same person will call at a pre-arranged time, building confidence over a period of 8 to 12 weeks. The Alzheimers society also provide companionship for people with dementia and their carers that supports them to continue hobbies and carry out regular activities. FDF are also working to provide a volunteer befriending scheme for people with disabilities.

Respite services – The Carers Trust North Wales offer ‘Gwalia Care’ which takes over the roles of the carer so they are able to take some time out. This can be on a regular or ad hoc basis and is chargeable.

Age Connects North East Wales (ACNEW) – ACNEW are part of the national Age Connects Cymru programmes, a social enterprise providing support for people aged 50+. Locally, the services provides short-term housing related support, toe nail cutting, a cleaning and shopping service and social activities.

Education and Learning – Many local projects are referring people to the University of the Third Age (U3A). U3A provide opportunities for retires and semi-

retired people to come together and learn, not for qualifications, but for ‘it’s own reward’.

Single Point of Access (SPoA) - SPoA is multi-agency initiatives in Flintshire providing support for adults. By telephoning just one number an individual will be able to speak to someone about community health, wellbeing and care services. Access to information, advice, assistance, assessment and co-ordinated care will be available. SPoA also supports a co-ordinator who can advise and signpost to organisations within the Third Sector.

DEWIS - Dewis Cymru is a website that aims to help people with well-being, whether that’s their own well-being or the well-being of a family member or friend.

The website contains information that can help people think about what matters to them and has information on services that can be accessed for support. Organisations across Wales can upload their own information to the site.

Flintshire benefits from a strong third sector presence and networks and a positive relationship between the Council and Flintshire Local Voluntary Council (FLVC). The Wellbeing Team in FLVC and AVOW (Association of Voluntary Organisations Wrexham) supports the third sector and statutory partners in a number of ways:

- Promoting third sector organisations, services and activities to statutory partners
- Representing the third sector at strategic planning and partnership groups
- Engaging the third sector in consultations and engagement about health and social services
- Promoting partnership working within the third sector and across sectors
- Signpost to or provide business support and funding
- Provide training to organisations to improve their capacity and effectiveness
- Explain the complexities of commissioning and procurement
- Help keep services up to date with the latest evidence base, and guide you through the changes in NHS and local authority structures.
- Help the start up of new services or groups
- Support the third sector in Flintshire and Wrexham to access FLVC and AVOW’s services

Recently, the team have consulted with health and third sector colleagues on ways to improve communication between the two, and regularly hold network events, with the last one themed around training and workforce development.

The Social Services and Wellbeing (Wales) Act 2014 encourages new approaches including co-operatives and social enterprise. The Welsh Government funded organisation Wales Co-operative Centre are able to provide support to services moving to this model.

6 Current Approaches within Health

Make Every Contact Count (MECC)
Making Every Contact Count is an approach developed by the NHS to encourage positive behaviour change through the millions of day to day interactions that organisations and individuals have with people. 'MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations' (NHS, 2016) The Population Needs Assessment recommends that the MECC programme should be implemented and embedded (2017).

Well North Wales
The idea for Well North Wales has been developed from the 'Well London' Programme which involved community development work with a health focus. The needs are raised by the community and actions are then developed to address them. The programme looks more holistically in to the needs of the community and instead of focusing directly on health needs, can look more widely at other issues which will have an effect of a person's health, such as debt and housing.

The project aims to introduce a place-based programme in areas of high deprivation in North Wales, working with multiple agencies and stakeholders, as well as representatives from the local communities, to develop initiatives based on priorities identified by the communities themselves. There will be an emphasis on mapping the changes over the years, developing social prescribing and training will be provided to staff on Asset Based Community Development.

Communities have been identified for support in North Wales that are on the periphery of areas which have seen a lot of investment over the years from Communities First and other programmes, but have not received the same level of investment, but are still high on the Welsh Index of Multiple Deprivation.

These areas are:

- Llangefni
- Upper Denbigh
- Penycae

A Board has been established in the Shotton area to work develop an ex-steelworks social club and the adjacent land into a potential Health & Wellbeing Centre, based on community need, where services can be co-located.

Eirias Park
The Health Care and Wellbeing Precinct, based at Colwyn Leisure Centre within Eirias Park is a collaboration between Betsi Cadwaladr University Health Board, Conwy County Borough Council and the Welsh Rugby Union. It sees health, social care and leisure professionals working together to improve the health of people by

applying physical activity to manage chronic disease conditions and to assist rehabilitation from acute or chronic ill health.

Care Closer to Home
Through the ‘Care Close to Home’ Programme, the NHS were looking at a range of options to modernise care. These included new technologies, providing care in community settings, and systems to direct patients to the right teams to provide care rather than via a GP.

Care Home Response Teams
This approach, whereby multi-disciplinary practitioners would be based within a team and provide the right care to individuals in care homes at the right time. This satisfies the requirements of both Part 2, Section 15, and Part 9, Section 16 of the Social Services and Well-being (Wales) Act 2014, in providing a “range and level” of preventative/early intervention service. (Flintshire County Council, 2016). BCUHB are currently testing the model with a select number of care homes in the west of the region. The programme is in the very early stages of development.

Vanguard Sites in England
50 Vanguard sites have been chosen across England to develop new innovative care models under three categories. ‘Integrated primary and acute care systems join up GP, hospital, community and mental health services, whilst multispecialty community providers move specialist care out of hospitals into the community. Enhanced health in care homes offer older people better, joined up health, care and rehabilitation services’ (NHS England, 2016).

The document ‘New Care Models: Vanguards - developing a blueprint for the future of NHS and care services’ outlines the programme in more detail, with examples from across the sites, two of which are outlined below. Lessons learnt can be reviewed alongside any local work.

<table>
<tr><td>Connecting Care - Wakefield District
Dedicated teams of health and care professionals are being allocated to support care homes and supported living schemes in looking after the health and wellbeing of their residents.

Each of the 15 care homes and two supported living facilities in Wakefield that are taking part in the vanguard are being linked to a dedicated GP practice which works with mixed teams including community nurses, therapists, voluntary carers and other professionals to provide a flexible, efficient and responsive service that reacts to the needs of residents. The team aims to avoid ill health among residents by taking action before people become unwell, reducing the need for reactive care and unplanned hospital admissions.</td></tr>
<tr><td>Gateshead Care Home Project
More than 2,500 people live in residential and nursing care homes in the area. The programme is building on the extensive range of services to work together to support people in care homes, to improve patients’ experience and reduce unnecessary hospital admissions. This includes Care Home ‘Ward Rounds’. More complex patients that need care planning and/or collaborative specialist decision</td></tr>
</table>

making to manage their condition spend an average stay of 4 weeks on the case load of a 'Virtual Ward'. There has already been a 14 per cent reduction in avoidable hospital admissions.

7 Areas for Consideration

This section explores other possible actions that could be considered for the medium to long term. For each area, the information below will outline:

- Background
- Examples
- Potential local application

7.1 Community Agents and Links

Bolton et al (2017) describes a range of community based approaches which can help deliver services to people in communities in a different way. These will be explored in more details, and include:

- Local Area Coordination
- Community Circles
- Local area coordination
- Wellbeing Teams

"Local Area Coordination (LAC) is an innovative approach to supporting people"… (and their families/carers) to achieve their vision for a good life, to support people to be part of and contribute to their communities and to strengthen the capacity of communities to welcome and include people" (Local Area Coordination Network, 2015).

Research led by Swansea University (2017) evaluated Local Area Coordination in the area and identified it contributed to significant positive outcomes for people, communities and local finances. These include:

- financial benefits of £800k-£1.2m (benefit cost ration of between 2:1 and 3:1), based on most conservative assessments
- expected benefits rising to between 3:1 to 4:1 when embedded within communities and partnerships established with services and partners
- the development of strong and enduring personal networks alongside individuals/families and across communities, with these connections being sustained without ongoing Local Area Coordination involvement – reducing isolation and building local resilience and control.
- Local Area Coordination "adding value across a range of public service pressures"

Community Agents Essex is a countywide network of agents and volunteers who support older people and informal carers to find and develop independent living solutions from within their local community (2017). The service is delivered through a community and voluntary sector partnership consisting of Rural Community Council of Essex, British Red Cross, Age UK Essex and Essex Neighbourhood Watch.

Between April 2016 and March 2017 the agents supported 3538 people presenting with independent living issues, 2192 people with information and advice and 1186 with mobility issues (Community Agents Essex, 2017) amongst others. 73.1% of those accessing the service fully achieved their goals around confidence and independent living.

Locally, Community Agents are also working in neighbouring Local Authorities. Wrexham's Community Agents aim to help those aged over 50 to achieve a better quality of life, by providing easy access to a range of information 'that will enable them to make informed choices about their present and future needs' (WCBC, 2017). The Agents are employed by Local Community Councils with funding from Wrexham County Borough Council (WCBC). AVOW have recently been commissioned to coordination of the project and provide support to the Agents.

In Denbighshire, Community Navigators are employed by the British Red Cross to act as a source of 'current and accurate knowledge about a comprehensive range of support available within the community. The support delivered is empowering and enabling (where possible) and promotes independence, confidence and skills, supporting the development of community initiatives' (British Red Cross (2017).

The navigators are accessible at community venues (Talking Points) at certain times of the week. The project reports:

- 369 citizens or 67% of all who attended a Talking Point were able to receive information, advice and/or assistance immediately which helped prevent their needs escalating.
- 67% reduction in Social Services waiting lists due to citizens visiting a Talking Point and gaining access to information about preventative services to help them to achieve their personal outcomes.

The Community Circles or Circles of Support model sees a facilitator bringing together family members, friends, community members and possibly service staff together to support individuals to meet their personal outcomes (Bolton et al, 2017). The facilitator supports the group to develop their conversations in to practical actions.

'Social Prescribing is a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector' (University of Westminster, 2017).

FLVC were commissioned in 2017 to undertake a 10 week 'proof of concept' project looking at the benefits of Social Prescribing' on a local level. Two staff within FLVC receive referrals from GPs who identify patients who they feel would benefit from the service. The Social Prescribers can meet with the person in 45 minute slots to discuss the issues that may be having an impact on their health and wellbeing. The

staff are then able to make referrals and link the person in to assets in their local community that may contribute to improved outcomes.

A need exists for people to be based within communities who can act as a bridge between community members and the services who are able to support them

Local application:
Elements of the above programmes can be taken to develop a mixed model approach to community development. The programme will need to be based on co-production principles to meet the needs of the communities identified.

7.2 Micro-care Enterprises

'Micro-enterprises (also called micro-providers) are very small organisations delivering social care services that employ five or fewer staff (full time equivalent). They are usually independent of any larger organisation and are offered by a range of people and organisations in the community, including people who are disabled or need support themselves' (Needham et al, 2015).

Research undertaken by Needham et al between 2013 and 2015 found that

1. Micro-providers offer more personalised support than larger providers, particularly for home-based care.
2. Micro-enterprises deliver more valued outcomes than larger providers, in relation to helping people do more of the things they value and enjoy
3. Micro-providers are better than larger providers at some kinds of innovation
4. Micro-providers offer better value for money than larger providers
5. Continuity of staff

'As a micro-care provider, it's about doing a small service well' (Community Care, 2013).

On enquiry, to date, it has been difficult to find information on micro-care providers in Flintshire as the definition is not widely used. No information of micro-care providers in Flintshire is listed online on 'the small good stuff' website, a directory of small care enterprises, CSSIW do not hold this detail of information, and Care to Co-operate and Business Wales have no records of working with organisations that fit the above definition.

Flintshire, does however, have a number of small Social Enterprises supported by a Social Enterprise Development Officer.

'Like traditional businesses they aim to make a profit but it's what they do with their profits that sets them apart – reinvesting or donating it to create positive social change. Social enterprises exist in nearly every sector from consumer goods to healthcare, community energy to creative agencies, restaurants to facilities management. Well known examples include The Big Issue, Divine Chocolate and the Eden Project but there are over 70,000 social enterprises throughout the country contributing £24 billion to the economy and employing nearly a million people.'

Source: Social Enterprise UK

In 2016/17, Flintshire's Social Enterprise Officer supported and 7 new start-ups and supported 24 organisations to thrive and prosper. These organisation have a wide remit, but examples from social care include:

A pilot programme was established in Oldham and Kent in 2008 by (NAAPs) to test a business model designed to support and stimulate the development of a range of micro care and support services. A full-time coordinator was employed to support the development of micro-care enterprises across the adult's social services. As a result of this work, a detailed guide has been produced to support Local Authorities entitled 'Supporting Micromarket Development: A Detailed Practical Guide for Local Authorities (NAAPs, 2009).

In January 2011, East Sussex County Council launched a Micro Market development project focusing on adults with social care and support needs, and based on the learning from the NAAPS pilot. The aim of the project is to work with new and existing 'micro' providers (those with less than five paid employees) to help them understand what social care and support services people need and want in different parts of the county. In 2011/12, 7 brand new micro services were developed, and a further 16 micro services were supported to a position where they could apply to join the Council's Support with Confidence scheme.

The numbers have continued to grow and in 2016 there are over 65 micro providers, 35 of which are Support with Confidence members (East Sussex County Council, 2016). The team offer the following services based on what commissioners have said they want:

- Advice, support and resources from Adult Social Care and local voluntary sector and business support organisations to develop a business or idea
- Opportunities to promote your business, service or activity through events and the Council's Support with Confidence Scheme
- Opportunities to network with other local 'micro' providers and be kept in touch with new developments

From the work, a number of services have been developed, covering dementia support, mental health services, home care, music therapy, PAs, hairdressers, day opportunities and well-being therapies (East Sussex, 2017).

Community Catalysts provides this support on an independent basis in Somerset to release local people's capacity to care through supporting 200 small, self organising enterprises, who provide services for 600 older people, employing 180 people. Community Catalysts reports that '32 community micro-enterprises in rural West Somerset are delivering £134,712 in annual savings. Projected across the 171 micro-enterprises supported by Community Catalysts in Somerset, the project delivers £719,867 in annual savings. The one-off cost of the Catalyst is £135,000 over 2 years. 56% of people supported use direct payments, showing a direct and ongoing annual saving to the council of £403,126'. The project has also helped to drive a 43.6% increase in uptake of direct payments (2017).

Local application:
Flintshire County Council to explore undertaking a feasibility study in to the need for Micro-care enterprises in the county.

7.3 Marketing and Recruitment Campaign
The sector is facing a significant image crisis which is having repercussions on recruitment and retention. This has been identified as a significant need thorough the Business Diagnostics, by local providers attending the steering group as well as being a national issue. Alongside this, media coverage of the sector had tended to focus on high profile negative cases of abuses of older people. This presents a negative image of the sector that may deter people from entering in to it.

As of May 2017, the draft North Wales Workforce Development Strategy prioritised the need for a campaign across the region. The strategy outlines actions in terms of marketing and recruitment and retention (North Wales Social Care and Well-being Services Improvement Collaborative, 2017).

Recruitment and Retention within the commissioned health and social care sector	Joint initiatives across the sector to promote and attract individuals to health and social care as a career of choice
National Development of a health and social care Marketing Campaign	Work with National Organisations to support marketing campaigns that improve and value the health and social care sector.
Assets Based Recruitment	Through work with the independent sector it was identified that through recruitment staff that remained and provided great quality care were those whom had the right values base. Work with the third sector could support the use of assets based recruitment, through training and information.

Skills for Care, the English equivalent of Social Care Wales, produced an Adult Social Care workforce Strategy and implementation Plan (2011). The implementation Plan outlines a number of areas and actions to be taken forward including:

- Promoting Social Care
- Attracting a diverse workforce
- Managing new interest and recruits
- Retention
- Research and intelligence
- Standards, learning and qualifications

An evaluation of the implementation plan took place in 2013 and found that there has been a number of success (Skills for Care, 2013). A new strategy covering 2014-2017 (Skills for Care, 2014) has since been produced, reflecting on the 2011 strategy.

There are opportunities to utilise online solutions. Flintshire County Council hosts a Foster Carers Portal to give potential new Foster Carers an opportunity to find out more information on fostering and the way support is provided in Flintshire. In a secure area Foster Carers can log in to access forms, payslips, policies, training, news and useful information. A similar arrangement could be developed for social care providers in Flintshire.

A number of provider support websites exist in England. These are run by local Care Associations or similar, independently of the County Councils. They cover a wide variety of information including:

- Searchable care providers database
- Information for care providers
- Careers in care and vacancies
- Members area
- Local care awards information
- News/ newsletters
- Social Media links and contact details
- Details of companies providing advantageous services for members
- Training, events and workshops

Local application:
Alongside providers, develop a central point for a marketing and recruitment campaign for the local care sector. Information targeted at different audiences will seek to challenge the negative stereotype of working in the care sector and provide information on vacancies and careers in care. The 'portal' could also keep providers and carers working in the sector up to date and open up new channels of communication between the Local Authority, providers and their staff.

7.4 Shared Lives
The Shared Lives model see older people, or other vulnerable adults or young people, sharing the home of a carer and their 'family life', where they can receive support to live well. The State of the Nation Report on Shared Lives Cymru (2017) reports that people in Shared Lives arrangements feel 'greater levels of independence and fulfilment' and that 900 people are supported, although the majority are people with a learning disability and only 3% receive support associated with their age, however, the programme is supported by the Older People's Commissioner and is seen as an 'important alternative to traditional models of care'. The model can also include day support and short breaks, alongside live-in support.

Wrexham County Borough Council (WCBC) have developed a variation on the Shared Lines model. Shared Lives Carers work on a self employed basis and work with people in their own homes as opposed to the older person moving in with them.

There are currently 32 Shared Lives Carers who support up to 3 people. The carers aim to:

- support people to live independently, maintain hobbies and leisure activities, access community based activities and make informed choices
- provide personalised quality care and support to individuals to maintain their emotional health and wellbeing

The programme shares the difficulties of recruiting carers, resulting in long waiting lists for the service as a result of the matching process.

A Shared Lives service is also available in Portsmouth, using the live-in care model, and were rated 'Good' by the Care Quality Commission in 2015. Other Models can

be found throughout the country and details can be found on the Shared Lives website and reports.

Local application:
A feasibility study could be undertaken looking at the needs, with good practice could be taken from schemes across the UK and implemented in Flintshire.

7.5 Homeshare
From previous chapters we have explored that many older people living alone feel isolated and need to rely more on help from family or formal social services to remain independent in their own homes. This scheme differs from the Shared Lives model, as instead of the older person sharing the home of a family, a younger person will share the home of the older person to support with household activities in exchange for affordable accommodation. There are now a number of programmes running across the world (HomeshareUK, 2017)

Leeds Beckett University (Allen et al, 2014) undertook research to 'reveal Homeowners' and Homeshares' expectations of the scheme; the demand for the service; and how much people would be willing to pay to join the scheme' in the Leeds area. The research found:

Benefits
- Companionship
- Feeling of security having someone else in the property
- Cultural exchange
- Reduced cost for housing maintenance and support services
- Improved physical and mental health for the homeowner
- Avoiding the 'bedroom tax'.
- Good standard of housing for younger people
- Integration between generations.

Concerns
- Anxiety on who would be matched
- What would happen in the future and how it would affect the arrangement
- Physical and emotional demands of caring/supporting and older person
- Uncertainty about living with a stranger
- Effects on benefits and finances
- Conflicts and disagreements
- Trust
- Restrictions on day to day activities or loss of independence
- Master-servant relationships
- Privacy
- Reluctance to ask for help from the Homesharer

The key factor to overcoming these issues would be the support provided from the service or organisation overseeing the Homesharing scheme from the matching process right through to the end of the placement. Further information on the benefits, risks and examples of Homesharing can be found in the Homesharer Practice Guide (NAAPS, 2011).

The co-housing arrangement is modelled after a Dutch example where students live in a nursing home and spend time socialising with the residents. Since 2015, a pilot project named ‘A Home that Fits’ has been taking place in Helsinki, Finland, with the aim to reduce youth homelessness in the city as well as to tackle feelings of isolation by care home residents. Three apartments have been opened up to young people aged 18-25 in a care home. The young people take part in activities with older people, going to events and baking for example. The project reports that the “The youngsters have brought an energy and positive spirit into the place with them. It is a very simple model that would be easy to spread to other countries” (Guardian, 2017).

The UK benefits from a network for Homeshare which aims to ‘helps people who need support such as older people, stay in their own homes for longer and provides affordable accommodation for younger people or key workers, at a time of record housing shortages and high rent (Homeshares UK, 2017).

Young people share the home of an older person and help them with light household duties such as washing and ironing, enabling the older person to stay in their home for longer. The younger person commits to supporting the home owner with 10 hours of duties a week, and in return, they will receive a room and facilities rent-free. This arrangement does not include personal care.

There are now 25 Homeshare schemes registered in the UK. The organisation, linked with Shared Lives Plus, have developed a detailed guide for homesharing covering risks and benefits, values, funding, links to legislation and how to deliver as scheme (Shared Lives Plus, 2016).

The most local to Flintshire are in Liverpool and Shropshire. Knowsley Housing Trust run a homeshare scheme which ‘enables older householders to live more independently in their own home for longer, sharing their skills with someone younger who is looking for a place to live rent free and is willing to help around the home (KHT Homeshare, 2017). Other similar schemes run around the country including Leeds, Manchester, Worchester, Northamptonshire, London and Isle of Wight, all operating in different ways.

Local application:
This could be explored as an option for development in Flintshire. Alternatively, the feasibility of developing a Homeshare model in care homes where accommodation exists that is not suitable for elderly residents.

7.6 Support for Unpaid Carers
The Social Services and Wellbeing Act (Wales) 2014 act removes the requirement that carers must be providing a ‘substantial amount of care on a regular basis’. Carers now have the same rights as those they care for and Local Authorities have a duty to offer an assessment to any carer where it appears to the Local Authority that a carer may have needs for support. If the local council determines that a carer’s needs meet the eligibility criteria then they must consider what could be done to meet those needs (Population Needs Assessment, 2017).

Carers UK reported in 2015 that the value of the contribution made by carers in the UK is now £132 billion each year (Carers UK, 2015), with 18,216 in Flintshire who's care was valued at £386 million.

Currently, Carers are high on the agenda, but it is important not to lose sight of their importance as we move forward, and strive to support them in their roles as much as possible. Engagement activities carried out with Carers and reported in the Population Needs Assessment (2017) identified the following gaps in service:

- Lack of transport in rural areas
- Lack of services in rural areas, including paid home carers
- Inability in some areas to make appointments with known/named doctor, which is needed for consistency, particularly for people with mental health needs or dementia
- Lack of awareness among primary care staff about carers, their importance and needs
- Insufficient counselling services for carers whose mental health is affected by their caring role; this is particularly important due to the impact and stress of caring role
- Insufficient range, availability and flexibility of respite and short breaks for carers
- Gap in support for carers of people with substance misuse issues
- Long-term, sustainable funding for carer support projects

The Population Needs Assessment also outlines wide ranging support to assist carers in their role and to support them specifically. Flintshire County Council currently commissions NEWCIS to run support services for Carers. This includes undertaking carers assessments, respite care, carers grant, support and training.

The organisation itself has also been awarded £999,182 for the development of a Carers Wellbeing Service, launched in June 2017 (NEWCIS, 2017). The service, alongside Citizens Advice and Advocacy Services North East Wales (ASNEW) will provide information and advice, advocacy, carer breaks, counselling and activities.

Flintshire County Council are committed to involving carers in the development of services, and in 2015 held an event named 'Taking Carers in to 2020' which looked at carers priorities and have explored some ideas around future support. This has fed in to the development of Flintshire's Carers Strategy, overseen by the Carers Strategy Group.

The regional Planning Partnership Board is collating information and carers stories. The final report is due to be published in March 2018 will improve our current knowledge base and will present recommendations on how to address identified gaps. Consideration must be given to the outcomes of this report and where we can further support unpaid carers in their vital roles.

Local application:
Whilst much is taking place to support unpaid carers in Flintshire, we must review the outcomes of the regional work once published.

7.7 Staff Benefits and Support

There are a number of examples of how employers are supporting their employees. This section will focus on the following three.

- Keyworker housing
- Wellbeing initiatives
- Rewards

Affordable housing, especially for first time buyers is difficult. Many social care workers find it difficult to get on to the housing ladder due to non-guaranteed hours contracts and although there is work taking place to change this in Wales, there is more we can do on a local level. Encouragingly, options around key worker housing to include social care managers and registered nurses is currently being explored.

Other areas of the country have developed these schemes, traditionally for health care staff and social workers. Haringey in London allows qualified social workers to take out an equity loan, repayable when the property is sold (Haringey, 2017).

The Department of Health's Factsheet on 'Health care staff wellbeing, service delivery and health outcomes' (2014) outlines the 'strong relationship between healthcare sector staff wellbeing and performance outcomes'. It goes on to state that 'organisations should promote staff wellbeing as it is important in its own right and it can improve the quality of both patient experience and their health outcomes', as well as reducing staff turnover and improving attendance. Introducing wellbeing schemes could have an impact on sickness rates, which are estimated at an average of 10.5 days a year in adults services in England (Quality Watch, 2017).

Flintshire County Council has bought in to the Carefirst Employee Assistance Programme. Carefirst provides confidential, impartial advice and support 24 hours a day, 365 days a year, online or via the freephone telephone number. The service is free for all employees to access whenever they need it.

Carefirst offers free and confidential assessment, short term counselling and follow up services to employees who have personal and/or work related problems. These can include from complex issues affecting mental and emotional well-being, such as alcohol and substance abuse, stress, grief, family problems and psychological disorders. A similar form of support may be of benefit to those working in the sector to build a resilient, supported workforce. The effect on sickness levels and retention levels can be monitored alongside and implementation.

Locally, RCS are a non-profit organisation based in Rhyl are 'Mind Hacks for Workplace Wellbeing' session to small/medium businesses in September and October 2017. The sessions look at positive language, coaching and communication and wellbeing interventions for the workplace.

A number of companies are also offering money to those who refer people for jobs. Local Agency Jane Lewis are currently offering a £500 joining bonus to nurses joining the agency which they will receive after completing 100 hours work. Other agencies are providing bonus of up to £250 for staff for referring support workers. This may not be possible for small agencies however.

There is now an increasing amount of work taking place to recognise and celebrate those working in the sector. Local Care Associations in England are developing Care Awards, like the one held by Surrey Care Association (Surrey Care Association, 2017). Now in it's 9th year, this is an opportunity to celebrate and raise the profile of the good work that takes place within the sector. In Wales, there are Wales Care Awards, covering 20 categories. It is important to promote this opportunity on a local level.

Local application:
The Council could explore wellbeing initiatives to providers. This could also be developed through a purchasing consortium or Care Association in the future, co-produced with the sector. We must also promote the Wales Care Awards and celebrate the great work taking place alongside the sector. Opportunities like those provided through RCS will be shared through the Provider Portal.

7.8 Nurseries in Care Homes
Generations United, base is the US, have developed a number of resources for developing intergenerational shared site programmes. The 'Under One Roof' guide outlines some the rationale for shared spaces, which reflects the UK in that the US's older people's population is increasing, the demand for parents to work and the result that older people and the very young are spending significant time with care providers. Children and older people are spending less time together, despite walking the 'same streets'.

Shared sites can be structured to meet the needs on multiple generations and provide integrated services, building mutual relationships. The sites become Intergenerational Learning Facilities.

Benefits to this approach include:

- Young and older people working together sharing knowledge, skills and enjoyment.
- Maximising available resources (financial, materials and people)
- Tackling loneliness and isolation which the Population Needs Assessment (2017) has highlighted as a cause of concern.
- A different offer to staff and residents
- Increased physical activity
- Business sustainability and innovation
- Volunteering opportunities across the age range

Considerations to be given to developing this work further, highlighted in 'Under one Roof' (2005) include:

- Set up – A co-produced mission statement and goals
- Legal and accreditation requirements
- Facility design
- Funding and partners
- Staff development and training
- Curriculum Development and Intergenerational Activities (including maximising the informal curriculum)
- Marketing

- Evaluation

Generation United (2006) also report the following benefits.

Children

- Preschool children had higher personal/social developmental scores by 11 months than those not in shared sites.
- Improved perceptions of older people, people with disabilities and care homes
- Parents surveyed believe it was beneficial for their children

Older people

- Residents report the setting is more "family/home like" and promoted renewed interest in others.
- Positive effects for people with Dementia that carried over once the children had left.
- Using modified Montessori activities, adults with mild to moderate levels of
- cognitive impairment were able to act as mentors to preschool age children
- and showed significant increased level of constructive engagement accompanied by a decrease in passive engagement when mentoring
- Residents reported feeling happy, interested, loved, younger, and needed. The most common aspects of the program that they enjoyed were the children's playfulness and affection.

Staff

- Staff are positive about the programme.
- On-site childcare led to reduced staff turnover.
- Enhanced career
- opportunities by providing cross training and professional development for staff

Community Relations

- Improved relations through positive publicity
- Increased community involvement

Cost-benefit

- Onsite child care typically added revenue-generating space to long-term care facilities which often report under or unutilised space
- Use of resources readily available - shared staff (e.g. nurse, receptionist, occupational therapist, physical therapist, kitchen staff, maintenance, and security), equipment and supplies (e.g. copier, washer/dryer, computers, phones, vans/buses and kitchens).
- Multiple funding streams available to one premises.

There are a number of examples of shared spaces across the US. Opened in 1991, the Providence Mount St. Vincent in West Seattle provides both planned and spontaneous activities in their campus, which is also home to 400 older people. They come together for activities including, crafts, singing, dancing, or just visiting. The

children are able to learn about the aging process and disabilities and enjoy the company of older people while residents benefit from increased physical activity, enjoy the 'spirit and joy that children bring to the home environment' and serve as role-models (Providence Health Services, 2017). A film about the services called 'the Growing Season' will be released on 2017.

Apples and Honey nursery will be opening a second venue at the Nightingale House Residential Home in London in September. This venture is the first of it's kind in the UK and aims to tackle loneliness and isolation as well as bridge the gap between the generations. The facility has been established as a social enterprise and are working on a wide range of research projects which will be released along their journey. They have sought advice and support from a number of educators, therapists, accountants and marketing professionals (Apples and Honey, 2017).

"*As an old person coming to the end of my life, it's a great joy to see new human beings growing, and growing up slowly, into people, into humanity, into maturity. It's a wonderful thing"* (BBC News, 2017).

Further examples of the impacts the interactions with children can have with older people can be seen in the TV documentary 'The Care Home for 4 Years Olds' where pre-schoolers share their classroom with older people over six weeks.
http://www.channel4.com/programmes/old-peoples-home-for-4-year-olds/episode-guide/

Local application:
This model could be explored and links be made between local Care Homes and Nurseries.

7.9 Purchasing Consortiums
'A purchasing consortium can be defined as a collaborative arrangement in which two or more organisations join together to combine their individual requirements for goods, works or services to gain better prices, design, supply availability and assurance benefits compared to if each member purchased the goods or services alone' (Farrington, 2006).

There are a number of advantages for being a member of a Purchasing Consortium service. Due to the scale of what is being purchased, the service will have greater negotiating power to get the best mix of price and quality for the product. The consortium may be able to spend time sourcing products from a number of suppliers that would be time consuming for and individual provider.

The provider Business Diagnostics undertake in 2017 report that purchase of consumables is one of the biggest challenges faced by the sector locally. The purchase of consumables, utilities, equipment, waste services, HR services and well-being services could all be considered though a consortium in the future.

A number of purchasing consortiums serving Care Homes and Nursing Homes already exist. Some examples are outlined below.

IDC Ltd supplies fresh milk, bread, fresh meat and fruit & vegetables to nursing and care homes throughout the country. By using a network of over 500 local and regional supply partners, IDC helps reduce food miles while supporting local businesses and the communities they serve.

Greetwell Purchasing Solutions - Providers of a comprehensive purchasing service tailored to the specific needs of the care home market. As well as negotiating preferential terms and trading agreements with suppliers they actively co-operate with clients in developing a purchasing strategy on products such as food, furniture and medical equipment.

Spectrum Consortium is used by Berkscare. Spectrum is a well established buying consortium with an emphasis on the care sector including care homes, domiciliary care and supported living. They have been sourcing discounts with major suppliers for their members since 1992. Their directors are all care home operators with significant experience in the industry and have therefore developed an expertise in negotiating excellent deals and sourcing the right products. Membership is free of charge

In many cases, care homes can join a purchasing consortium through a Local Care Association, which will be explored further in the next section.

Local application:
To explore with providers the advantages and the appetite for establishing a local purchasing consortium.

7.10 Care Associations

Local Care Associations work to represent the interests of the providers signed up. Many hosts websites, which contain useful information on the care sector, as well as membership areas where providers can sign in for more information and access support.

Many Care Associations have developed or signed up to the purchasing consortia and their services can be accessed through becoming a member of the Association. Fees stand in the region of £230-£300 to join a local Care Association. Some have been set up as not-for profit enterprises or social enterprises.

A number of examples of Care Association are outlined below:

National Care Association - http://nationalcareassociation.org.uk/
The National Care Association representing small and medium sized care providers and affiliated local associations and liaises with national Government and other stakeholder groups on their behalf. The membership fee for a home with over 45 beds is £500.

Berkshire Care Association (BCA) – BCA seek to foster co-operation between care providers by providing information, training, support and guidance to promote high standards of care. They organise members meetings, training courses and other events and attend meetings with commissioners in order to represent the views of

care providers. There is a cost to membership at £240 for one service. BCA use Spectrum as a purchasing consortium.

Staffordshire Association of Care Providers (SARCP) - http://sarcp.net/
SARCP is an association representing over 200 independent Care Providers including Care Homes and Home Care Agencies in discussions with government agencies. SARCP strive to influence policy makers and successfully voice members opinions ensuring that members are given sufficient representation in the sector. SARCP has an Executive Committee made up of eleven independent care provider proprietors/senior Managers and professional consultants.

Members are given helpful advice and kept informed of changes both nationally and locally ensuring that they are aware of factors that impact the sector. Staff development is important to Members and SARCP not only facilitates training courses but distributes Skills for Care Workforce Development Funding to support staff development and recruitment. The membership fee stands at £27.

There is scope to develop a Local Care Association with a website at the centre. The Care Association could seek to provide the following services at an appropriate fee.

- Purchasing consortium
- Central point for county DBS checks and certificates making sure they are transferable with the employee
- Website with vacancies, news, events, training etc
- Training and event
- Network meetings – Provider meetings, Activity Coordinators conference, Managers learning hubs
- Collate/share best practice in line with CSSIW inspection themes
- If established in a social enterprise format – small grants pot to fund activities to get people out in to the community, bring the community in/ intergenerational work

Local application:
To explore with providers the need to establish a local care association and how it can be developed in a co-productive way.

7.11 Technologies

Technology also has a huge role to play in social care today. This area will focus on some aspects, but this is a very broad area and the information outlined here does not do justice to the possibilities available. If this an area for further development, a separate investigation is required.

There are a number of elements to this area:

- The technology required to enable the care services to run effectively
- Interacting with services through technology
- The assistive technology needed for people as they grow older.

Positively, a statistical bulletin from the Office of National Statistics (ONS, 2017) reports that the use of the internet by those aged 65 and over is catching. Recent internet use in the 65 to 74 age group has increased from 52% in 2011 to 78% in

2017 indicating that as we move forward, this trend will continue, with more older people becoming IT literate. However, today, only 4 in 10 adults aged 75+ have used the internet in the past 3 months.

It is important to not use technology solely at the expense of, or in isolation to other sources of information and support. A multi-strand approach is always preferable to enable individual choice and fair access to services.

The use of technology is beginning to become more common across Social Services. 34.7% of those who responded to a survey at the Association of Directors of Adult Social Services in England spring seminar in 2016 said that their Authority recorded data electronically at point of interaction with individuals or carers, although, of those who said yes, only 7.69% said that more than 75% of their workforce was doing so (ADASS, 2016).

Regional partners have already identified the need for accessible shared IT systems at a workforce development event in North Wales to facilitate a more effective transfer of information between services. The introduction of e-Referrals in Cumbria (through Strata) has been a catalyst for improved communication and goodwill between health and social care partners. Efficiency savings to date across the local area are estimated at £400,000 per year (IPC, 2016).

Locally, a domiciliary provider has invested in smart phones for all staff can now access their schedules through an app. Feedback has been positive with staff becoming accustomed to the new smart phones quickly.

Advantages include:

- Managers being able to know the location of staff as they will check in at a call and check out once complete. This also provides reassurance re: lone working.
- Calls that are shorter/ longer than expected can be monitored. This will provide a more effective service considering the changes in the Domiciliary Framework
- Staff are no longer able to swap calls between themselves or provide cover without prior permission.

The 'Transforming social care through the use of information and technology' report (IPC, 2016) outlines a number of examples where technologies have been utilised to support people.

East Sussex Council have developed the Telecheck service to enable people to stay in their homes for longer. The service makes telephone calls to service users to remind them eat, drink and take medication, as well as contact and reassurance to the individual. The service has demonstrated an approximate 'cost avoidance value of £32 per client per week and has estimated preventative savings of £589,000 in 2014/15' (IPC, 2016). £4m of savings were made over 3 years in Hampshire by targeting the use of assistive technologies by employing an outcome based approach to identify what the individual would like to achieve.

Wrexham County Borough Council (WCBC) have a Telecare House in Wrexham located in a sheltered housing complex, just outside Wrexham town centre. The Social Service offers a 'drop in' where people can view the equipment available in a home setting and discuss their needs with an Occupational Therapist or a Disability Officer.

Cera offer a range of smart home appliances and monitoring sensors that can be managed from a smartphone and can arrange for a doctor to visit the home the same day, or consult over the phone, via text or video message (Cera, 2017). Other innovative approaches have been developed by Cera, including a digital platform which allows domiciliary care providers to update the system on the services they deliver and the care received by elderly people. Unpaid carers and relatives can log in to keep up-to-date on what is being delivered, which provides reassurance and transparency. The system also allows people to find out more about the carer, make any requests, schedule visits and manage payments.

Technology is also a focus at some of the Vanguard sites in England. In Nottingham, blood pressure monitors and video consultations are being introduced to care homes whilst another in Airedale include live video links to health professionals around the clock via access to a hub of senior nurses who can give advice and support (NHS England, 2016).

Inventor's BenignEye sensor monitors vulnerable at home
An inventor has designed a sensor to support elderly people living alone and which provides details if there is anything out of the ordinary. Tim Jones from Penyffordd, Flintshire, was inspired by his mother Beris who lived independently until she died from cancer in 2016.

He began to explore ways of recording how she moved around the house and used appliances for peace of mind, before deciding to make the device for others. Mr Jones worked with Glyndwr University in Wrexham to design BenignEye which he is hoping to take to market.

Source: BBC News 22.09.17 http://www.bbc.co.uk/news/av/uk-wales-41352906/inventor-s-benigneye-sensor-monitors-vulnerable-at-home

Local application:
Continue to develop ways in which assistive technologies can be utilised in Flintshire.

7.12 Older people as part of the workforce

A 2011 study suggests that by '2030 older people will benefit the UK economy by around £291.1billion, compared to projected welfare costs of £216.2billion'. The Ageing Well in Wales programme aims to help to maximise the contribution of older people to their communities and wider economy (Ageing Well in Wales, 2014).

One of the key priorities of the Ageing Well in Flintshire Action plan is providing opportunities for learning and employment whilst understanding that some older people face particular challenges in entering or maintaining employment. 'Lifelong learning is critical not only to maintain a competitive position in the labour market, but

also for wider health and wellbeing benefits. Learning and skills development can include (but is not restricted to) financial and digital inclusion to help older people to become more resilient in later life' (Flintshire County Council, 2016).

Many local providers have highlighted that the workforce is ageing. They find that these staff are experienced and trustworthy and will leave a void when they decide to leave service. Concerns have also been raised that these employees may be lost as a result of the new regulations brought in under the Registration & Inspection (Wales) Act 2016 and by Social Care Wales. Social Care workers will need to register with Social Care Wales by 2020, at a proposed cost of £35. In order to register, the worker needs to have achieved an award in Social Care and to work towards a Diploma in Health and Social Care in the first 3 years of registration.

Entry in to the sector has been described as attractive to the older workforce due 'to the low barriers to entry and flexible working patterns' (Eastwood, 2017). In light of these new regulations, employers feel that staff, of any age, may not undertake this additional training and costs when other employment opportunities are available locally without these additional barriers.

'US care providers are finding that a different approach is required to attract this group. They have had most success when their recruitment messages align care work to the perceived goals of workers at this life-stage: that it keeps you physically active, it's socially good, it enables you to feel valued and useful and allows you to build meaningful social relationships. Word of mouth recruitment is also seen as particularly effective, especially if an enthusiastic older team member is willing to spend time on community outreach' (Eastwood, 2017).

Support is being developed for employers looking to employ people over 50. The Department of Work and Pensions (2017) has developed a webpage for guidance and Prime Cymru, the The Prince's Initiative for Mature Enterprise in Wales also supports those over 50 in to employment opportunities and can also assist organization advertise vacancies (2017).

Local application:
This area is explored further as part of the recruitment and retention work stream with lesson learnt from other campaigns targeted at over 50s.

7.13 Transport

'Community Transport is a safe, accessible, cost-effective and flexible form of transport. It can be developed to directly address gaps in public transport provision and create noticeable and lasting social and economic benefits.

Community Transport is of particular value to people who, for a variety of reasons do not have access to a car or public transport. It also provides a lifeline in both rural and urban areas, catering for a variety of needs and situations' Flintshire County Council (2017).

Older people are increasingly accessing Community Transport schemes. In Wales 94% of community transport organisations had older people as service users in 2013, an increase from 83% in 2010 (Community Transport Association, 2014).

The importance of these organisations is also highlighted by the Older People's Commissioner (2014)

Lindsay Haveland, from the Community Transport Association (CTA), covering North Wales has observed a number of issues which may put services at risk in the future.

Issues highlighted include:

- Funding
- Age of organisers
- D1 licences and cost
- The inflexibility of the legislation which disables organisations from making a profit which can be used for expanding the provision. The non-profit aspect of section 19 and 22 permits does create a barrier to achieving financial sustainability and as a result community transport organisations are very much reliant on funding/transport subsidies (Community Transport Association, 2015).
- The drop in the use of service since users were unable to use their concessionary travel cards with providers (WG decision)
- The availability of Blue Badges to operators. Many passengers will have their own, but some who do not may only leave their house when they are being taken by one of the Community Transport Operators.

There are two community Transport organisations in Flintshire, Welsh Border Transport and Estuary Voluntary Car Scheme.

Welsh Border Community Transport has six minibuses, four of which can carry wheelchair passengers. Organisations and individuals pay a small membership fee which allows them to book a bus when they require it, societies, clubs, care homes and churches. Shopping trips to local supermarkets are arranged for elderly people, helped by funding from Flintshire County Council. The Community Car Scheme takes elderly and disabled people in Buckley and Deeside for medical appointments. All car drivers are volunteers who use their own cars.
http://www.flvc.org.uk/en/members/welsh-border-community-transport/

Estuary Voluntary Care Scheme is a registered charity where all the drivers are unpaid volunteers. The scheme currently operates 8 vehicles, 6 especially

converted to be able to carry wheelchairs. The scheme is NOT intended as an alternative to a Taxi service and a booking should be made at least a week before transport is required. Services are available for medical appointments, shopping for older people and social activities.
http://www.estuaryvoluntarycar.co.uk/index.html

Flintshire County Council are working with local communities to develop localised Community Transport Schemes. A provision has just been established in Higher Kinnerton via the Community Council as part of a pilot scheme for the Flintshire Community Travel Project. A further eight areas will join the scheme including Northop Hall, Connah's Quay, Penymynydd, Penyffordd, Buckley, Treuddyn, Llanfynydd and Holywell (Deeside.com, 2017)

The Council have also developed a toolkit which 'aims to assist Community Councils and organisations in developing community transport opportunities' and provides 'advice and guidance in order to consider establishing a community transport provision' (2017).

The CTA's 2014 report of the state of the sector outlines the growing pressure on Community Transport with the number of passenger miles increasing from 4.3m in 2010 to 6m in 2013, and the number of journeys increasing from 1.2m to 2m in the same period.

The Welsh Assembly undertook an Inquiry into Bus and Community Transport Services in Wales Survey in 2015. The findings, published in 2016, made 12 recommendations, which the Welsh Government agreed to 9, two in principle and rejected 1 (Welsh Government, 2016).

Local application:
The positive work undertaken by Community Councils to develop community transport links in their area needs to be shared throughout the network to encourage others. Also, the provision of Blue Badges to Community Transport Operators could be explored.

7.14 Housing

The links between poor housing and poor health have long been documented. The BRE estimate that the avoidable UK costs of poor housing to the NHS has risen from £600 million in 2010 to £1.4 billion (Nicol, Roys and Garrett, 2015). If there was an investment of £10 billion pounds to 'improve all of the 3.5 million 'poor' homes in England, this would save the NHS £1.4 billion in first year treatment costs alone' and that this investment would pay for itself in seven years with the benefits continuing into the future.

There are a number of national programmes and services dedicated to improving the living conditions of the most vulnerable. Healthy Homes, Healthy people (HHHP) is a Wales wide project and work is taking place in Flintshire to improve the health and well-being of those involved. Officers from the Council's Environmental Health Department are working with front-line staff including Health Visitors and Social Workers to identify vulnerable people who may need support with their housing conditions. Care & Repair North East Wales will continue to provide healthy homes

visits to help more residents (owner-occupiers). An assessment form is used to refer people to other sources of support which could include debt advice, tenancy support, home improvements and energy efficiency (NEA, 2017).

NEST is the Welsh Government Warm Home scheme offers home improvements at no cost to applicants who own or privately rent their home, live in a property that is very energy inefficient and receive a means tested benefit.

The Flintshire Local Housing Strategy 2012-2017, sets out the vision for proving new affordable homes, making best use of the existing housing, improving the quality of homes alongside how the Council envisages helping the more vulnerable members of our community.

Further afield, The Lightbulb Project in Leicestershire works to help people stay 'safe and well in their homes for longer' (Housing Learning & Improvement Network, 2017). Badged as an 'invest to save' programme, the approach is targeted and proactive and includes GPs and other health/care professionals including those in integrated locality teams.

'The process relies on early assessment and triage of housing issues at key points of entry. This is delivered through a 'hub and spoke' model with an integrated Locality Lightbulb Team in each District Council area' offering:

- Minor adaptations and equipment
- Disabled Facilities Grants
- Wider housing support needs (energy, home security)
- Housing related health and wellbeing (Assistive Technology, falls prevention)
- Planning for the future (housing options)
- Housing related advice, information, signposting
- The common, central functions (management, performance, Lightbulb development etc) will sit within the central 'hub'.

The service also includes a specialist Hospital Housing Enabler Team based in hospital settings, both acute and mental health, across Leicestershire to work to resolve issues that may be a barrier to discharge and prevent readmissions. Delivery costs are approximately £1m p/a against a potential £2m p/a saving to the Leicestershire and savings to the wider health economy. 11% of the total cases have been analysed and 66% of these show a reduction in the use of service and adult social care costs were reduced by 23%, two months post intervention.

This is an area that could be developed further though integrated working and co-production. It is recommended that the work taking place on a local level be mapped and evaluated to show the benefits to households.

Local application: Continue with implement the Healthy Homes, Healthy People Programme and the 'next steps' outlined in the report following the HHHP Conference in 2017 and drive forward the 2025 movement, which aims to reduce avoidable healthy inequality in North Wales.

7.15 Co-operatives and alternative business models

As the sector looks towards a more personal approach to providing care, it is important to consider new ways of working. Opportunities to develop Micro-care enterprises have been explored above, but further alternatives will be outlined here.

The research report, 'Owning our Own Care' explored the development of multi-stakeholder co-operative social care in the UK (Co-operative College et al, 2017) provides a number of case studies where social care is being delivered differently utilising different models, including charities, co-operatives and community interest companies

The report concludes by setting out a number of lessons learnt from the processes gone through by the services interviewed and some recommendations as we move forward. The Social Services and Well-being Act is hailed as 'ground-breaking' in its requirement on local authorities to encourage the development of community and service user-led services and that the view that commissioners hold the most power in the market is being challenged in 'the most progressive local authorities'.

In response to the Social Services and Well-being Act, the Welsh Government have funded the Welsh Co-operative Centre to run 'Care to Co-operate' to support the development of social care co-operatives, consortia and social enterprises across Wales. The project has supported the development of the Community Lives Consortium in South Wales, a Company Ltd by Guarantee with full charitable status, registered as domiciliary care agency supporting people with disabilities (Wales Co-operative Centre, 2016).

There are examples of care homes run as charities. Brian Boxall-Hunt, who has supported Belvedere House in Surrey (Carehomeuk.co.uk, 2014) explains one of the fundamental differences between a charity and commercially run care home.

"We are a not-for-profit organisation and our commercial aim is to break even, not make a profit. This means we can plough everything back into the care and the staff."

"This means that we can keep fees and costs low and quality high. We are also proud to pay our staff a proper wage well above the minimum wage and above the living wage. Our staff turnover also is low – an indication of a happy staff."

The Co-operative Life (TCL) is an employee owned co-operative based in Sydney which provides care for the elderly and disabled people. Workers are directly involved in the business in relation to salary, work rotas, training and care packages provided to individuals. Any profits are reinvested back in business.
http://www.getmutual.coop/wp-content/uploads/2015/10/CHC.pdf
The Co-operative Life (TCL) is an employee owned co-operative based in Sydney which provides care for the elderly and disabled people.

Local application:
Local providers can to be introduced to the possibilities available in social care through co-operative working with support from the Care to Cooperate. Further examples need to be identified. The Council could also explore opportunities to invest in alternative governance models for the delivery of social care services for example, running care home provision in partnership with independent providers.

7.16 Supporting Social Workers

At a recent conference, one delegate explained how we should understand that Social Workers are 'allies' and we should look at ways of developing and encouraging creativity in social work.

Although difficult to do due to the immense pressures on social services, Social Workers must be allowed some time to look at the most recent research coming from the Social Work Policy Institute and others and to be able to share innovative ideas, especially as the Act directs staff to work in a more person focused and innovative way. The Chief Social Worker for Adults in 2014 wrote:

"Social workers need to undertake research to deepen their practice and – crucially – opportunities for the" "work workforce to undertake reflective supervision and quality assured continuous professional development" (Department of Health, 2014).

Social Workers need access to journals and share information from evidence based practice training. There are examples of social services research strategies and social work research role linked with NHS.

Local application:
Conversations could take place with staff teams to see how this could be taken forward in a practical way.

7.17 Income Generation

Many Councils are moving towards a more commercial approach to operation to balance out the impact of budget cuts. An example comes from Sheffield City Council, who developed and income generation team, who looked at opportunities to maximise income across portfolios.

West Lindsey's District Council Corporate Plan 2016-2020 outlines how it is looking to develop 'a commercial approach to areas normally receiving grant subsidies and investing in the community and voluntary sector'.

Others have developed Local Authority Trading Companies (LATCs). These are private businesses which are run by Councils, able to operate as a commercial operation and generate income which can be used to expand the business or reinvested in council services. An example here is Tricuro, a company owned by Dorset, Bournemouth and Poole Councils, providing social care services across the areas (Tricuro, 2017). It is hoped that through this approach, 'all three councils can retain the quality and range of services by sharing their resources, as well as enabling staff to work flexibly and efficiently. It can develop and enhance its services to provide the appropriate level of care and support to meet the needs of people in communities'. Other examples include NorseCare, based in Norfolk.

Key lessons for public entrepreneurship and innovation in local government
The key lessons for public entrepreneurship which emerge from the study can be summarised as follows:

- Entrepreneurial managers can foster a commercial culture amongst staff. Taking a proactive attitude to expansion and diversification drives forward innovation.

- A commitment to valuing and developing the workforce can go hand-in-hand with public entrepreneurship.
- Focus on income generation as a means of generating investment in local services.
- Assure democratic accountability and oversight of new public organisations.
- Pre-empt and address risk within the business model for new activities.
- Explore existing legal powers as a means of catalysing entrepreneurial activities.
- Take full advantage of entrepreneurial opportunities to act as stewards of local economies and communities

Source: Municipal Entrepreneurship (APSE, 2012).

Local application: Flintshire County Council could explore opportunities to develop a more commercialised approach and identify opportunities for income generation.

7.18 Reablement

Reablement is a programme of short-term assessment and support, designed to help people regain or maintain independence. Reablement builds on what individuals can do. In Flintshire, reablement is a free service for a short period of time. This can be just one week or up to a maximum of six weeks, depending on the needs of the individual. Reablement aims to maximise long term independence, choice and quality of life.

Evidence outlined in SCIE'S research briefing on reablement (2014) suggests that this approach is having a significant long lasting effects on the recipients. For example, in one study 76 per cent of reablement users did not need services up to four months after completion. The briefing outlines further research to take in to consideration.

Currently, there is a risk to local reablement capacity as the team are picking up work where there is no capacity within domiciliary providers, which is having an effect on capacity.

Local application:
To promote reablement approaches within services and to the independent sector. The sector could be supported with training and information to enable them to use this as part of their work.

7.19 Trusted Assessors

Timely assessments are essential to providing the right care at the right time. This is sometimes difficult to undertake due to capacity and can lead to a delay in the provision or transfers of care. Trusted Assessors programmes could provide a solution to these delays. Trusted assessors work on 'behalf of and with the permission of the provider' to undertake the assessments.

NHS Improvement (2017) states that 'trusted assessment is a key element of best practice in reducing delays to transfers of care between hospital and home' and could prevent multiple assessments taking place. The document 'Developing trusted assessment schemes: essential elements' outlines a core criteria to be considered

for trusted assessment and could be adapted as a guide across other health and social care services.

To create a safe trusted assessor model, care homes and hospitals should co-design and agree a protocol or memorandum of understanding for assessments, documenting who can carry them out, what competencies are required, how they will be delivered, what the review mechanisms will be and what will happen if the receiving service judges that the assessment is flawed. Source: NHS Improvement (2017) Rapid improvement guide to trusted assessors.

Local application: Partners could identify opportunities where other services could undertake assessments on their behalf.

7.20 Direct Payments

The direct payment, in conjunction with an individual's Care & Support Plan, enables the person to exercise greater choice and take control over how their care and support needs are met. The Social Services and Wellbeing (Wales) Act 2016 promotes the use of direct payments.

Good practice examples include supporting people with Learning Disabilities to take control of their care and commission providers using direct payments. Flintshire County Council has worked in partnership with three young men and their chosen support provider to pool their direct payments and commission a new model of supported living aimed at supporting increased independence, a positive risk enablement culture, greater use of available technology and support that is tailored to individual learning and development needs.

Flintshire County Council currently commissions The Penderel's Trust to provide support to direct payments recipients. The Provider's services are available to Flintshire County Council direct payment recipients and other people who use services interested in the scheme. The services includes:

- support and enable direct payments recipients to effectively run and remain in control of their personal direct payments.
- Contribute to the development of the direct payments scheme in Flintshire through partnership with all stakeholders recognising and valuing the distinctive contributions each party can make
- support and enable people who use services to live independently
- empower people who use services to take control of their own lives
- enable people who use services to make choices regarding their own care or support

The service achieves this through:

- offering information
- advocacy (on direct payments issues). The provider may also refer direct payments recipients to advocacy services provided by other agencies
- providing and/or arranging training and support across every stage of the direct payments scheme process. Assisting existing direct payments recipients to maintain the Scheme's accountability checks and contractual requirements as set out in the 'Direct Payments Scheme Agreement'.

- providing support for Practitioner training re. direct payments

In the 2016 direct payments satisfaction survey (Flintshire County Council, 2016), most decided to take up direct payments because they wanted ‘control over personal care’ (29.5%) followed by ‘Gaining independence, social skills and giving respite to carers’ (21.7%).

Local Authorities across North Wales have developed a draft Regional Direct Payments Policy as the overarching framework to which social care professionals will refer to when enabling people to take greater control of their support solutions via a direct payment.

Local application:
Develop local operational guidance to implement the regional Direct Payments Policy.

7.21 Personal Assistants (PAs)
‘A personal assistant (PA), is someone who is employed directly by a person who needs care and support. They can also be employed by a family member or representative when the person they’re supporting doesn’t have the physical or mental capacity to be the employer. A PA always works directly with the individual they’re supporting, in a person-centred way, to enable them to live their life according to their wishes and interests’ (SCIE, 2017).

Skills for Care estimated that, by 2016, that around 70,000 of the 235,000 adults and older people receiving a direct payment directly employed their own staff, which would create 145,000 PA jobs.

A network has been established locally to enable PAs to receive support from their peers.

At present, there is no indication that the requirements laid out through the Regulation & Inspection of Social Care (Wales) Act will be extended to Personal Assistants, despite their role being comparable at times to those working in domiciliary care. This does not meant to say it will not happen in the future. We must ensure we are in apposition to support PAs if they are affected by legislative changes.

Penderel’s currently provide a PA finding service which is an online register of PAs looking for work. Employers in search of a PA are able to access this database.

Local application:
The provider portal could be extended to include Personal Assistance to assist in the facilitation of the network and to share information about the role and opportunities available. Small co-operatives of personal assistants could be developed.

7.22 Intermediate Care
With both the NHS and care providers feeling these pressures, we must look at innovative joint solutions which ultimately, enable people to stay in their homes for longer and reduce the amount of time people stay in hospital when they are well, but

not ready to return home. In data produced by Stats Wales, 125 people were subject to a delayed transfers from Flintshire between January and July 2017. Intermediate care looks to bridge the gap between hospital and home.

Definitions of Intermediate Care:

- Intermediate care can provide free temporary care of up to six weeks, either at home or in a residential home following a hospital stay (Which, 2016). It is a step down facility from skilled care, the care provided is by licensed practical or registered nurses (Highland Risk, 2014).

- 'Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital' (SCIE, 2017)

Intermediate care can deliver better outcomes for people and reduce the pressures on hospitals and the care system (NHS Benchmarking Network, 2015).

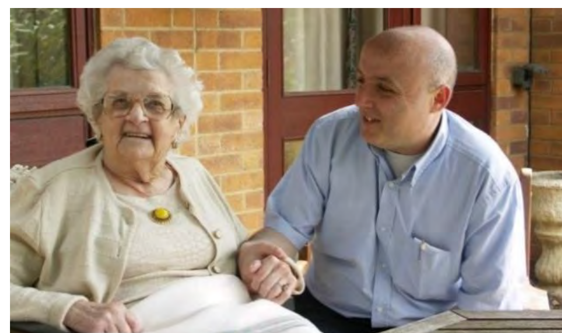
- 70% of people who received intermediate care after a hospital stay, returned to their own home
- 92% maintained or improved their dependency score
- 72% did not move to a more dependent care setting

Yeovil District Hospital purchased 18 beds at Somerset Care's nursing home in Yeovil (Cooksons Court) to become intermediate care rehabilitation beds. Members of the hospital's Rehabilitation Team work alongside Somerset Care nurses as a single team. They identify and assess patients in hospital to determine outcome goals and, with consent, transfer them to Cooksons Court for a ten-day period of intensive reablement. At the end of the period they are assessed and discharged home, with or without home care and support, as required.

The overall aims of this collaboration was to improve patient flow at Yeovil District Hospital, reduce unnecessary length of hospital stay, maximise patient clinical outcomes and reduce ongoing costs of care.

The program has had a significant impact, with:

- 402 admissions to Cooksons Court by April 2017
- 95 per cent of people were discharged home from Cooksons Court
- 42 per cent of patients required a reduction in their predicted home care packages upon discharge
- £1.6 million savings in ongoing care costs to the local authority
- Feedback from people who have used the service shows the extent to which they have valued the care and expertise of staff.



Local application:
Whilst considering the extension to one of Flintshire's in house care homes, provision could be made for the development bed-based intermediate care.

8 Recommendations

8.1 Immediate attention

- Build our case to Welsh Government for increased resources for the sector.

- Learning from this report to be shared with other Local Authorities and partners.

- To continue to involve our Social Care Partners in the development of our local approaches to support the sector.

- Further data is needed on current business models in social care (including social enterprise models such as community interest companies, and third sector ownership). This information is not currently collected. Flintshire County Council to lobby CSSIW and Social Care Wales to collect this data in light of the emphasis put on these through the Social Services and Wellbeing (Wales) Act 2014.

- The Council to support the development of apprenticeships and placements in independent providers and to lobby Welsh Government to introduce further support for training social care staff given the pressures that may be imposed on the sector through the introduction of new regulations.

- Lobby the Welsh Government to collect information across the workforce on EU nationals working in social care and monitor the effects of Brexit.

- Feasibility studies to be undertaken exploring:
    - Micro-care
    - Purchasing Consortiums
    - Assets Library

- The Council to work with the Third Sector Well-being Network to develop opportunities for Third Sector Health and Social Care Services to feedback to the Council on any issues arising and solutions to enable better communication.

- The Council continue to work with the Third Sector Well-being Network and other partners to map and understand the current local use of Social Prescribing models.

- Flintshire County Council to explore extending the provision of Blue Badges to Community Transport Operators.

8.2 Medium-term attention

- Flintshire County Council to give further consideration to the programmes outlined in section 6.

- Continue to support the local Marketing and Recruitment Campaign

- The Council to consider investing in the recruitment of a marketing graduate to develop the campaign for the social care sector further with allocated budget.

- A clear understanding of the complexities of the commissioning arrangements for social care to be developed in partnership with Procurement Officers, so all parties have an understanding of the sector, co-production, person-centred thinking and community benefits.

- In partnership, to develop an approach where MECC and What Matters Conversations are aligned, and to develop a public information campaign to share these tools to people in the community, who can then signpost and support citizen to access support to meet their needs.

- To establish a network or joint training group to develop training opportunities across Local Authorities, the Local Health Board and the Third Sector, reducing duplication and maximising the skills and expertise of all partners.

- The Council to develop a survey for the whole local social care workforce to feed in issues, concerns, solutions and examples of innovative practice.

- To develop and review our local Market Position Statement. Consultation on the regulations related to this are expected in summer 2018 as part of the Phase 3 consultation on the regulations for the Regulation and Inspection of Social Care Act (Wales) 2016.

- To annually review the current state of the residential and domiciliary care markets and to monitor any issues arising with providers over, looking to provide support where we can.

- Flintshire County Council to develop an update report taking in to account changes in legislation, funding and support in 12-18 months.

8.3 Long Term attention

- Support providers, if appropriate, to consider developing a Local Care Association to include a purchasing consortium and a celebration of the achievements of the sector.

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7 December 2017

Response from the Royal College of Nursing Wales to the consultation on the Finance Committee's inquiry into the cost of caring for an ageing population

The Royal College of Nursing Wales is grateful for the opportunity to respond to the inquiry into the cost of caring for an ageing population. As set out in the terms of reference, this inquiry is being conducted in the context of enormous strategic and financial challenges, and the Royal College of Nursing welcomes the Committee's consideration of these important issues. We would like to raise a number of issues in relation to the terms of reference:

Financial impact of current Welsh Government policies (including changes to legislation)

I. Increasing amounts of care is being provided in primary, community and social care settings within local communities, and the Royal College is supportive of this approach to better meeting the needs of the population. Nurses have a critical role in these services, particularly in nursing care for the older person.

II. During the consultation process for the Phase 2 Implementation of the Regulation & Inspection of Social Care (Wales) Act, we raised a number of concerns around the proposed regulations and guidance which had been drafted. These concerns related particularly to the staffing requirements of care homes delivering nursing care, and the proposal to no longer have a minimum requirement in relation to registered nurses working in care homes which include nursing care.

III. One of our main concerns relating to this was linked to the potential for these proposals to increase pressure on other services, which already experience massive demand which outstrips capacity e.g. District & Community Nursing teams, and out-of hours teams. As well as increasing costs for these services, the changes would also be likely to lead to an inevitable increase in the number of unnecessary hospital admissions. With increasing levels of integration and interdependence between services, it is vital to understand that making changes to one area of service will likely impact other areas of service elsewhere, and there will inevitably be cost implications to this.

IV. We were pleased that many of our concerns were heard and reflected in the revised regulations and guidance, although we would like to have seen them go further in some areas. There will now be a requirement that where an individual is assessed as needing 24-hour nursing care, there is a sufficient number of suitably qualified Registered Nurses deployed to work at the service at all times.

Costs of delivery of residential and non-residential care and the role of informal carers

V. It is widely understood that there are existing challenges around the recruitment and retention of nurses into care settings. The Royal College of Nursing has been advocating innovative idea of placing nursing students in the homes of unpaid carers, thereby providing relief for carers who often receive little to no respite from their roles as carers, whilst also providing placements for nursing students. It is often acknowledged that there is a lack of variety in nurse training placements, particularly outside of hospital settings. These training placements would provide valuable exposure for student nurses to a different care setting, potentially encouraging more nurses to work in the care sector. Equally, it would also help to overcome another widely understood issue of the lack of support and help available to those with unpaid caring duties.

VI. In addition to these training opportunities for nurses, there should also be the opportunity for unpaid carers to be recognised for the skills and expertise they possess thorough appropriate accreditation, providing qualifications and potential career opportunities providing nursing students with placements in the community provides a great opportunity for relieving pressures, giving unpaid carers the chance to gain qualifications. Not only would this give recognition to unpaid carers for the incredible job they do, it would also enable them to have a career beyond their immediate caring responsibilities in the longer term. The Royal College maintains that providing nurse training placements in unpaid carer settings could be a beneficial and cost effective model which could be rolled out across Wales.

Financial pressures on the social care system e.g. increases in wages

VII. In relation to wage increases, it is important to note that low or unfair pay is directly related with low workforce morale and reduced patient safety. Research from the Institute for Public Policy Research shows a pay rise for nursing staff would be good for the economy. It would generate extra GDP, return higher tax receipts and reduce welfare payments.[1] Any additional costs incurred from an increase to wages should therefore be viewed in the context of the wider benefits to the service overall. Also worth noting is that inadequate pay is linked to poor recruitment and retention of the workforce, which can result in health and care providers struggling to recruit and retain sufficient levels of nursing staff to provide safe and effective care for patients.

[1] IPPR 2017, *Lifting the cap: The fiscal and economic impact of lifting the NHS pay cap,* https://www.ippr.org/research/publications/lifting-the-cap

Reforms to the funding arrangements for social care

VIII. In the recent consultation on Charging for Social Care, the Royal College maintained that it is essential that care remains affordable for all and that any price increases to the cost of non-residential care should not be the start of a series of ongoing charging increases, particularly as they are likely to affect the poorest in society most severely.

Prudent Health Care Principles

IX. The Royal College of Nursing is very supportive of the Welsh Government's own commitment to the Prudent Healthcare Principles, and health and social care for older people should be delivered according to these principles. Whilst reducing costs should never be the driving force behind service change, if the four prudent principles are truly embedded in the system, then the quality and outcomes of care should be improved while the costs of delivering that care are reduced.

X. For instance, it is widely maintained that co-production can create more cost-effective processes and lead to improved patient outcomes and experience. Similarly, whilst streamlining and improving services to improve their cost effectiveness usually requires up-front investment, if the prudent principles are applied, the money freed up from greater efficiency can be reinvested into improving quality of services for patients. The Committee may want to look at existing examples of prudent principles being put into practice with a view to measuring the cost benefits and/or implications.

XI. Finally, the Royal College of Nursing would like state that although there is of course a cost associated with a population that is living longer, older people in society are a huge asset to our society and contribute significantly to the economy. It is important that a section of society is not viewed or portrayed as a financial 'burden' (as can sometimes be the case particularly with older people), but for the value that they bring to communities as well.

About the Royal College of Nursing

The RCN is the world's largest professional union of nurses, representing over 430,000 nurses, midwives, health visitors and nursing students, including over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

The Cost of Caring for an Ageing Population, Finance Committee inquiry, Social Care Wales response

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Social Care Wales is a Welsh Government sponsored body established under the Regulation and Inspection of Social Care (Wales) Act, 2016 to protect, promote and maintain the safety and well-being of the public in Wales.

Our aims are to:

- Provide public confidence in the social care workforce
- Lead and support improvement in social care
- Develop the early years and social care workforce

Key points

- **Social care services face significant demand pressures from an ageing population (par 1)**
- **Financial pressures have led to low pay in the social care sector which has a significant impact on recruitment (pars 2-6)**

To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care

1. Last year, we commissioned the Social Care Institute for Excellence (SCIE) to prepare a literature review about care and support at home. In terms of demand, the report found that social care services in Wales face significant challenges:

> "The demand for social care services and care labour is growing in the context of significant demographic changes and the growing incidence and large prevalence of complex, long term conditions. 'The ageing population means over a quarter of the population in Wales is aged 50 plus. Those aged over 65 are expected to increase from around 600,000 in 2013 to 900,000 in 2037 and the number of over 85s is growing at an even faster rate (Age Cymru, 2015). Wales also has a higher proportion of people aged 85 plus compared to the rest of the UK (StatsWales, 2012).' Population growth and demographic profile projections indicate that the supply side of social care is struggling to keep pace with demand. The data indicates that across the UK over half a million new care workers/home carers will be needed by 2022 (Howat et al., 2015).[1]"

To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts arising from the UK leaving the European Union

[1] Development of a strategic plan for care and support at home, literature review, Social Care Institute for Excellence (SCIE) for the Care Council for Wales (now Social Care Wales), 2016

2. Financial pressures have had a direct impact on the wages of social care employees. This in turn has had a significant impact on recruitment and retention. The terms and conditions of the care workforce are a significant obstacle to recruitment to roles which require increasing levels of complexity and skill and expectations to deliver more health-related tasks. This is further exacerbated by the disparity between NHS and social care pay levels.

3. SCIE's literature review on domiciliary care provided further evidence of the impact of low pay on recruitment:

> "Frontline roles within the care sector are generally perceived as low-status, low-skills jobs. This is reflected in the rates of pay, with most workers being paid at or around the National Minimum Wage. Low wages impact directly on the ability to recruit and retain staff particularly in the context of other sectors, including retail, being able to offer higher pay. 'Recent ONS data (Kirton, 2015) shows that unemployment in Wales, at 6.4%, is now around pre-recession levels and that pay has performed relatively strongly in retail as opposed to the more constrained public and associated sectors. Social care pay rates risk falling further behind other competitor sectors.'[2]"

4. The limits of what can be expected of care workers for what they are paid has been reached or exceeded. This is being demonstrated in difficulties in recruitment and retention of care workers and managers of care when alternative employment opportunities do not bring the same pressures and offer greater financial reward.

5. The disparity in pay between NHS health care support workers and social care workers is likely to be a major inhibitor to joint social care and health collaboration and the desire for seamless delivery.

6. We have commissioned research[3] which shows that the home care workforce is positively motivated by their role in providing care and support, however it also suggests that terms and conditions could act as a barrier to people who may wish to work in the sector.

7. The precise impact of leaving the European Union on the social care workforce in Wales is not known nor do we have accurate data on the proportion of EU workers in the social care workforce. In England it ranges from 4 per cent in the North East to 12 per cent in the West Midlands to 39 per cent in London[4].

To consider the financial impact of current Welsh Government policies - including recent social services legislation and reforms to social care funding - on local authorities, care providers and service users;

8. There is widespread anecdotal evidence that people are confused about paying for social care when healthcare is free at the point of delivery. This is particularly evident when people have very complex and/or long term health and care needs, who may

[2] Development of a strategic plan for care and support at home: Literature review, SCIE
[3] 'Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of care', Care Council for Wales / Welsh Government 2016
[4] The state of the adult social care sector and workforce in England, 2017, Skills for Care

also meet the NHS continuing healthcare threshold.

9. We have also received evidence from the sector that preventative support from community and third sector services are reducing, arising from councils and other bodies re-directing resources to statutory functions and critical services, due to budget challenges over recent years.

To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age

10. The demography of our society is changing, with increased need for public service support. We are an ageing society. The number of people aged 65 and over is projected to increase by 292,000 (44 per cent) between 2014 and 2039[5]. We see many more people in their middle years with significant disabilities who expect to live fulfilled lives. We are seeing many more children with significant disabilities or disadvantages who have high expectations of support that protects them and helps them to achieve their full potential.

11. Social care services are facing real and unsustainable increases in demand to meet society's needs. According to the Health Foundation, "pressures for adult social care are projected to rise faster than for the NHS, by an average of 4.1% a year. With funding unlikely to rise at the same rate, there is a real risk that the level of unmet need for care services could rise in Wales.[6]"

[5] National population projections, Office of National Statistics and the Welsh Government, 2015
[6] The path to sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31, Health Foundation, 2016

Welsh Assembly Finance Committee

Inquiry into the cost of caring for an ageing population

Written evidence submitted on the behalf of the RCEM Wales (January 2018)

The Royal College of Emergency Medicine Wales (RCEM Wales) is the single authoritative body for Emergency Medicine in Wales. RCEM Wales works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care.

1. The health service in the United Kingdom has been described as a victim of its own success.[1] On the whole, our population is healthier and living longer than ever before. As we will evidence below, a growing ageing population means we need to invest more into our health and social care services to adequately prepare and care for an increasing number of patients requiring complex care packages.

Ageing Population and Patterns of Demand

2. NHS Wales' medical and social care workforce faces a significant challenge to meet the health needs of a growing and ageing population with increasingly complex needs.

3. The figures given below are from Stats Wales collated from the Office of National Statistics.[2] What these figures show is that the population of Wales – which already had considerable needs centred around an ageing population – has continued to become more elderly. From mid-2013 to mid-2016 the population of those over 65 years of age increased by 5.7%. In the same time period, the population as a whole increased by no more than 1.0%.

Year	Population all ages	Population aged 65 and over
Mid 2013	3,082,412	600,630
Mid 2014	3,092,036	614,747
Mid 2015	3,099,086	624,773
Mid 2016	3,113,150	634,637

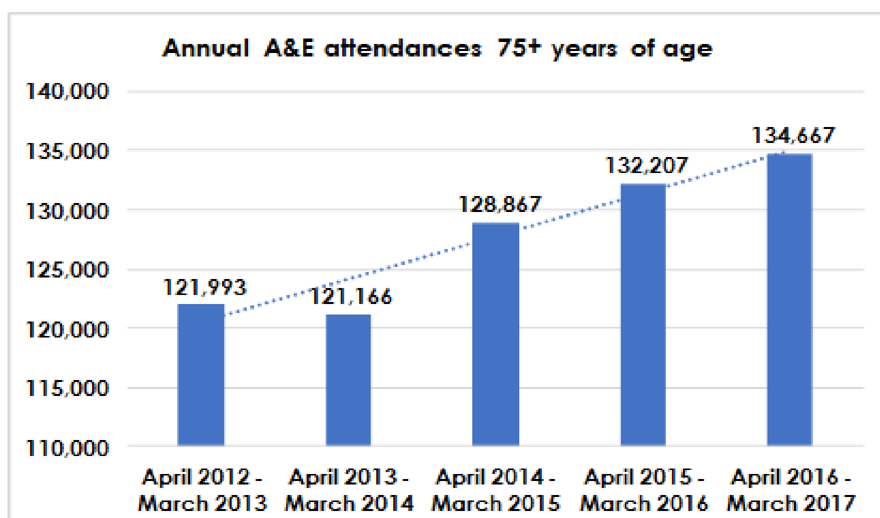
4. Moreover, the number of people over 65 years of age is predicted to grow by 229,204 by 2039. This is an increase of 35% in the space of only 21 years.[3]

5. While these changes are significant when considered on their own, they are compounded by the elderly populations changing attitude to their own health. Analysis of both Disability Free Life Expectancy and Healthy Life Expectancy data has shown that while life expectancies are increasing those same people's assessments of their remaining life expectancy in good health are decreasing.[4]

[1] Wales Online, Is the NHS "a victim of its own success" (2012)
[2] Stats Wales National Level Population Estimates by Year (2016)
[3] Ibid.
[4] ONS, Changes in Disability Free Life Expectancy (2016) and ONS, Health Life Expectancy (2016)

6. This in turn is reflected in an increasing propensity to access health and social care services. Demand from people over 65 years of age continues to grow considerably and has resulted in rising numbers of GP appointments,[5] demand for social care services and pressures in secondary care services, including A&E Departments.

7. The figures presented below are taken from Stats Wales. It shows that the number of A&E attendances of those over the age of 75 has steadily grown since 2013 by 11.2%. Although the overall number of Emergency Department (ED) attendances has only risen by around 2% in the same timeframe, the median time that patients over the age of 75 spend in an A&E Department can be three times longer than patients under the age of 75.[6] This is due to the complexity of conditions that accompanies older age.



8. A person with comorbidity has two or more significant clinical conditions. The likelihood of having two or more significant conditions rises to 60% by the age of 75 years and to more than 75% by 85 years.[7] In cases such as these patients inevitably need a higher level of care in both the hospital and community setting.

9. Indeed, the LE Wales has predicted that the number of over 65s requiring local authority funded domiciliary care or residential or nursing homes will rise by 47% and 57% between 2013 and 2030.[8] However, local authorities are already increasingly unable to meet demands for care and the responsibility of arranging care is often left to the patient and their families.[9]

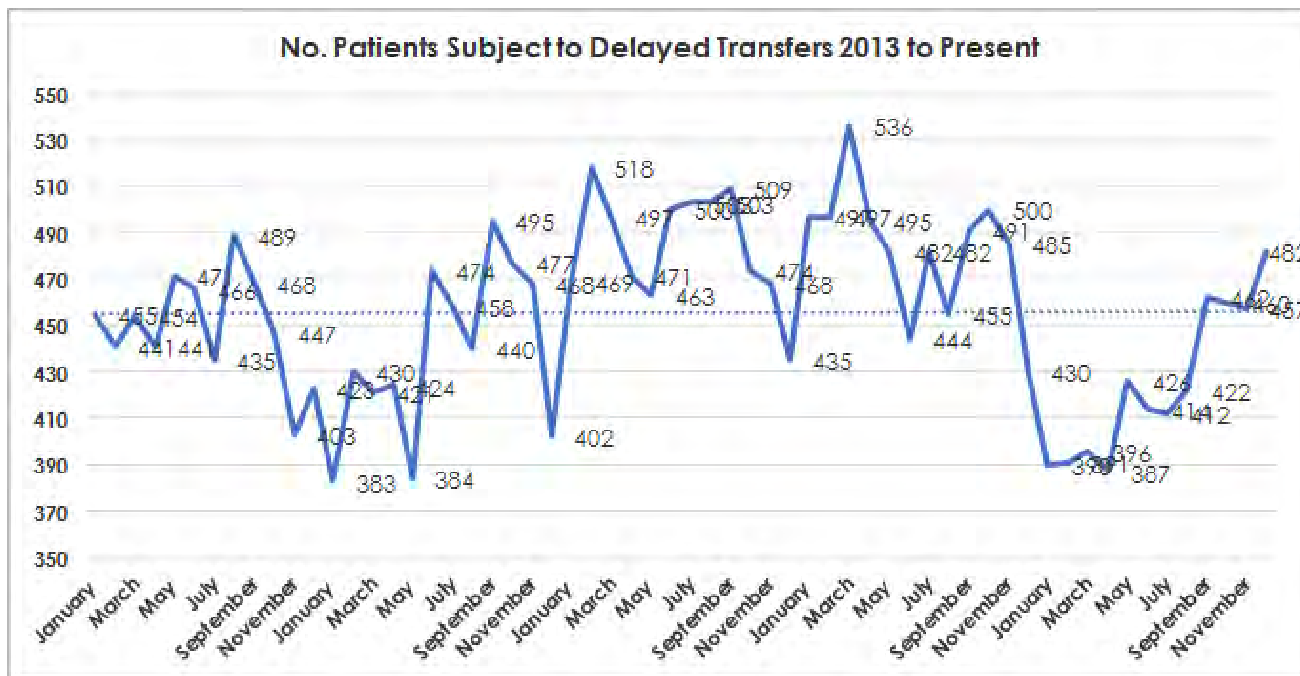
10. Insufficient social care resource impacts the entire the hospital system and contributes to ED crowding, 'Exit Block' and Delayed Transfers of Care (DTOC) – all of which are associated with negative patient outcomes. It is within this context that the RCEM takes the view that EDs have struggled in the face of rising demand, because we continue to systematically under-resource social care services. As we will evidence below, a lack of social care is not economical in terms of hospital expenditure and can significantly impact a patient's mental and physical wellbeing.

[5] The King's Fund, Understanding pressures in general practice (2016)
[6] Stats Wales, Mean and Median time spent in A&E and A&E Attendances by age band
[7] Dr Richard Day, Comorbidities in older people (2017)
[8] LE Wales, Future of Paying for Social Care in Wales (2014)
[9] Welsh Government, Parliamentary Review of Health and Social Care in Wales, Interim Report (2017)

The effects of insufficient social care in the hospital setting

11. One aspect of an ageing population is that more of those patients who enter hospital are more likely to need some kind of care package in place before they can leave. When this cannot be supplied in a timely fashion, those patients are subject to Delayed Transfers of Care (DTOC).

12. The chart given below shows the numbers of patients' subject to Delayed Transfers of Care in Welsh hospitals since 2013.[10]



13. This is important because the more patients subject to Delayed Transfers of Care – and the data does not specific how long each of these delays lasted – the fewer the available hospital beds to admit patients to when they arrive at A&E requiring further treatment.

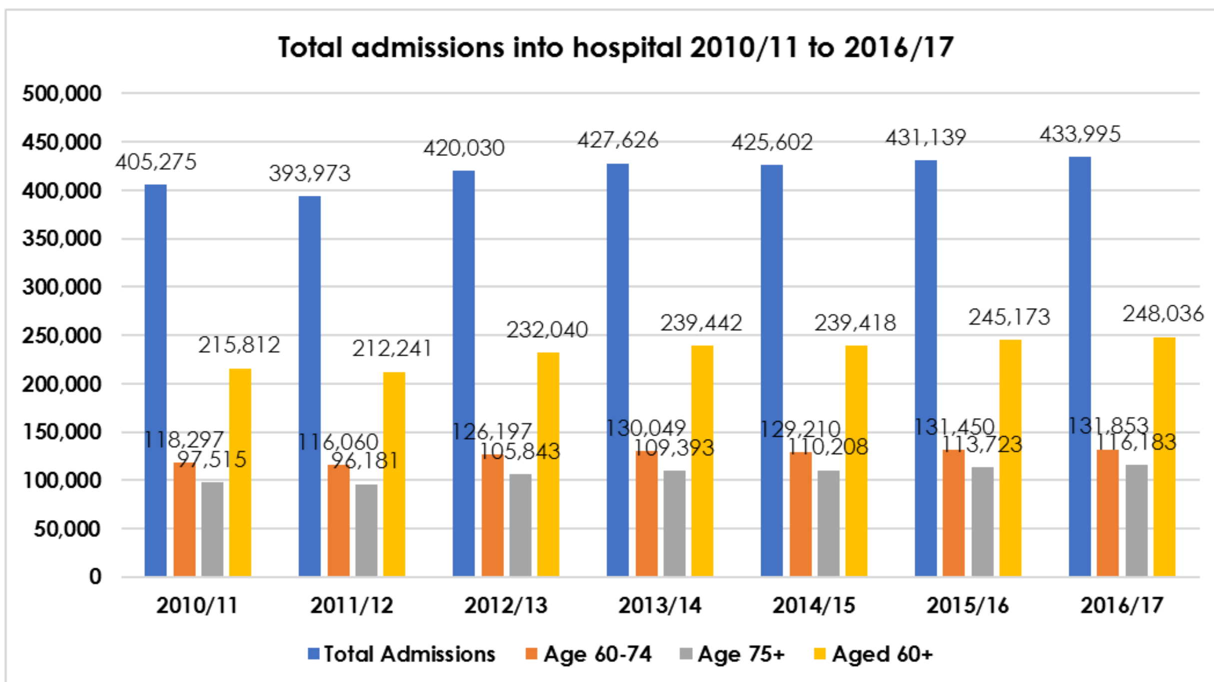
14. In over half of DTOC cases in Wales, delays are a direct result of hospital staffs' inability to discharge patients into an appropriate social care setting.[11] Whilst more people require care in the community, data from Stats Wales shows that the number of care homes in Wales for older adults has reduced by nearly 9% and therefore the number of places has fallen by almost 5%.[12]

Year	Total Settings (Older Adult Care Homes)	Number of Places
March 2011	704	23,340
March 2012	694	23,199
March 2013	684	23,050
March 2014	675	22,816
March 2015	670	22,713
March 2016	653	22,092
March 2017	642	22,217

[10] Stats Wales Delayed Transfers of Care by Organisation
[11] Welsh Government, Delayed transfers of care in Wales, 2016-17 (2017)
[12] Stats Wales, CSSIW Services and Places by Setting Type and Year

15. Furthermore, for those who no longer require hospital care but still need some form of care in the community, social care becomes increasingly important. This is in terms of long-term patient wellbeing and economical use of hospital resources.

16. An FOI request revealed that a stay in a hospital bed in the UK costs the NHS around £400 per day.[13] Data from NHS Wales Informatics Service shows a gradual increase in the number of admissions into hospital over the last couple of years – and a significant proportion of those consist of patients over 65 years of age.[14] The King's Fund bears this out and has found that patients over the age of 65 can account for 70% of bed days.[15] This means that the cost associated with elderly care in hospital is rising year on year.



17. More importantly, a frail person's ability to recover their former independence is greatly affected by a prolonged hospital stay.[16] Indeed, the Health Foundation estimates that 8-12% of admissions into hospital will result in harm to a patient.[17] The longer a person stays in a hospital bed, the greater the impact on their mental health and the more likely they are to develop a life-threatening hospital infection.[18]

18. The data for patients waiting more than 12 hours in an A&E Department is equally concerning. Since 2013-14 the number of patients' subject to these delays in A&E centres has grown from 11,502 to 33,834 in 2016-17.[19] This is an increase of 194.2% and this number is projected to rise.

19. Usually, four, eight and 12-hour breaches are a direct result of the lack of available and appropriate hospital beds – also known as 'Exit Block'. If there are insufficient hospital beds, in part due to a lack of social care, patients are more likely to have to wait longer in the A&E Department which can impact patient safety.[20] Indeed, prolonged ED waits are associated

[13] BBC News, Bed-blocking patient evicted after two years 'did not want to stay' (2017)
[14] Informatics Service, Annual PEDW Data Tables (2017)
[15] The King's Fund, Continuity of care for older hospital patients (2012)
[16] Ibid.
[17] The Health Foundation, Is the NHS getting safer? (2015)
[18] Forbes, 4 Ways Hospitals Can Harm You (2014)
[19] Stats Wales Performance against 12 hour waiting times
[20] RCEM, Exit Block: Hospital Demand Pressures and ED Performance in Wales (2016)

with several negative patient-oriented outcomes, including increased inpatient mortality rates.[21]

20. In order to answer what resources we require for the future – and looking at the data it is clear that we need more - we need to ask whether there has been any material changes in the funding for social care historically which would suggest that the situation was about to improve, rather than continue to deteriorate. Then we can determine whether both our health and social systems require a significant increase in financial aid and resources, rather than a continuation of the current trend.

Social Care Funding

21. The figures given below are from Stats Wales and detail NHS expenditure.[22]

Category	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Total NHS Funding (£)	1755.77	1759.10	1765.57	1803.82	1876.47	1,974.03
Social care needs (£)	14.45	13.99	14.69	15.93	16.18	18.68

22. Although these numbers are not adjusted for inflation, part of this picture is fairly positive. Social care funding has increased by 29.3% since 2010 and overall NHS funding in Wales has increased by 12.4%. Furthermore, between 2005-06 and 2013-14, expenditure by Welsh councils on social care services for people aged 65 and over has increased by 23%.[23] Using Wales Audit Office data, on the basis of these trends, expenditure could continue to rise to over £750 million within 10 years.[24]

23. However, considered more closely a different picture emerges. The Nuffield Trust - after adjusting for the fact that older populations have higher health needs and associated costs – evidenced that in 2015 Wales was the lowest spending UK Nation on its Health Service.[25] Moreover, the Health Foundation found that between 2008/09 and 2014/15, public spending on adult social care per head fell by an average of 0.4% per year (in real terms) in Wales. By comparison, funding in Scotland has risen by 0.5% a year.[26] This is despite Wales having a greater population made up over 65s than Scotland[27] and despite evidence suggesting that comorbidity is a key driver for social care costs.[28]

24. And yet these cuts are in the face of historical and projected growing demand. Indeed, the average life time expenses for social care faced by people aged 65 and over is estimated to exceed £30,000[29] and long-term care provision expenses is set to continue to rise.[30] The inevitability of an increasing number fail elderly with comorbidities will compound this.

25. For example, the number of people with dementia in the UK is forecast to rise to 2,092,945 by 2051 - an increase of 156%.[31] The cost of dementia in the UK was estimated at £26.3 billion in 2013, with 39% attributable to social care and 44% to unpaid care. Dementia patients often

[21] A. Singer et al., The Association Between Length of Emergency Department Boarding and Mortality (2011)
[22] Stats Wales, NHS expenditure per head by budget category and year
[23] Wales Audit Office, Supporting the Independence of Older People: Are Councils Doing Enough? (2015)
[24] Ibid.
[25] Nuffield Trust, NHS In Numbers & Health Spending Across UK Nations (2015)
[26] The Health Foundation, Health and social care funding explained (2017)
[27] ONS, Population estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2016 (2017)
[28] International Journal of Integrated Care, Who would most benefit from improved integrated care? (2015)
[29] Comos-Herrera et al., Expected lifetime costs of social care for people aged 65 and over in England (2010)
[30] Government Office for Science, Current and future challenges of family care in the UK (2015)
[31] Alzheimer's Society, Demography (2014)

have longer hospital stays than other inpatients, and are more likely to need social care after being discharged.[32] We need to account for this inevitable rise in demand for social care.

26. The Welsh Government recently acknowledged that "social care services are under substantial pressure at present, because of a large demand for local authority funded care, a squeeze on funding, and a shortfall in staff available"[33] – a view that is constantly repeated.

27. Nevertheless, the Government found that that access to alternatives to residential care - such as extra care housing, sheltered housing, and housing based support services - has significantly reduced.[34] Furthermore, capital costs for entry into the market and financial pressures has arguably dissuaded any new care home providers from setting up,[35] despite clear demand.

Staffing

28. The recruitment of health and social care professionals is declining at a time when people increasingly require treatment and support at home and in the community.[36]

29. Data taken from the Welsh Government shows that there has been a steady fall in the number of directly employed social services staff since 2009. Between 2016 and 2017 the total whole time equivalent staff fell by 5%. Moreover, in 2017 there were 2,762 home care services staff which is a 14% decrease when compared to 2015.[37]

30. There are numerous reasons why the recruitment and retention of social care staff is struggling. Many find better paid and better working conditions elsewhere, for example in the retail industry. Others find that the work is too stressful because of the demands placed upon them in an under resourced field.[38]

31. Although difficult to quantify, Brexit could pose a further risk to for the staffing of both health and social care services. According to the Nuffield Trust, 10% of doctors and 4% of nurses are from the EU and are working in the UK.[39] For social care, almost one in five care workers were born outside of the UK.[40]

32. If social care services are under significant demand now and are unable to adequately provide for their patients – due to insufficient financial provision and resource – it is fair to suggest that if the current trend continues, NHS Wales and Care and Social Services Inspectorate Wales will be unable to adequately provide for the frail elderly population of the future. We must therefore ensure that staff feel valued and attracted to work in Wales.

Conclusions and Recommendations

33. The situation laid out above is not a new phenomenon. Difficulties treating patients in a timely fashion because of a lack of available beds and social care in the community has been a feature of the Welsh and other UK health systems for some time. Planning must address the

[32] Government Office for Science, Future of an ageing population (2016)
[33] Welsh Government, Parliamentary Review of Health and Social Care in Wales, Interim Report (2017)
[34] Welsh Government, Parliamentary Review of Health and Social Care in Wales, Interim Report (2017)
[35] Public Policy Institute for Wales, The Care Home Market in Wales: Mapping the Sector (2015)
[36] Government Office for Science, Future of an ageing population (2016)
[37] Welsh Government, Local authority social services: Staff numbers in Wales, 31 March 2017 (2017)
[38] The Guardian, Social care in Wales: 'Brexit poses risks to staffing and services' (2016)
[39] Nuffield Trust, Fact Check: migration and NHS staff and Stock of doctors by country of first qualification (2016)
[40] Association for Real Change, Brexit and Social Care (2017)

need to cope with rising numbers of the frail elderly – with complex interactions between health and social care and long-term co-morbidities.

34. As acknowledged above, hospital care is a high-cost service and can also be detrimental to the health of some patients who are unable to be placed into community care in a timely fashion. Considering this, it is more logical to respond positively to the needs and demands of patients wanting care in the community. It is our opinion that the way to do this is to adequately finance the health and social care system and put in place social care services fit for the future.

35. There are too few social and community care staff to deliver effective and efficient care. We must ensure the work environment and shift patterns promote rather than discourage staff retention in these sectors.

36. The College's A&E Hub Concept proposes that frailty teams should be co-located alongside emergency departments to better meet the patient's need and reduce avoidable hospital admissions.[41] Early involvement of old age specialist teams has been shown to reduce length of stay in hospital and reduce inappropriate admissions, in addition to being preferred by patients.[42] Given the high cost of hospital admissions, introducing frailty teams at the front door might even be cost-saving for NHS Wales in the long-term and could lead to better patient outcomes.

[41] RCEM, Co-Location - the Hub concept (2015)
[42] British Geriatrics Society, The Older Person in the Accident & Emergency Department (2009)

Costs of caring for an ageing population

A Radical New Vision for Social Care.

The Socialist Health Association Cymru / Wales believes that any discussion of the costs of caring for an ageing population a sustainable way must look well beyond the present delivery model.

The key principles for any future system of long term care must include:

1. *Universal coverage* – The need for long-term care is part of the normal public sector services and should be treated just as health and education.

2. *Maximum risk-pooling* - The most efficient way of insuring ourselves against the costs of impairment or frailty is to all pool resources in order to cover that risk, as with the NHS.
3. *Equity* – The system should be equitable and should not discriminate against people because of condition, age or geography.
4. *Entitlement* – All citizens should benefit from the system and should not be disadvantaged by income or ability to pay. The system should be funded from general taxation and be free at the point of use, as with the NHS.
5. *Control* – All citizens should be able to get the right flexible support to meet their needs, to be able take the level of control that is right for them and their families.

The three key elements of the proposal are:

5. *Fund a universal system and end means-testing* – Social care on the same footing as healthcare, funded from general taxation, with resources distributed on the basis of need.
6. *Invest in citizenship and community* – Social care must offer support that people and families can shape to their circumstances, and that helps people contribute as citizens and strengthens family and community life.
7. *End privatisation and the complexity of the current system* – Social care must be integrated into one national system that invests resources locally and ends the wasteful procurement systems that currently undermine human rights.

Achieving these objectives will require an end of the failed policies of austerity and an acknowledgement of the crucial role of social solidarity, pooling of individual risk and service delivery through quality, accountable, public provision.

Welsh Government Challenge.
We recognise that the Welsh Government operates within resource constraints due to the UK austerity programme. In the decade to 2020 its budget will have been cut in real terms by 7% which means £1.2 billion less to spend on key public services. This places major constraints on what can be achieved in the short term but it must not place a barrier on the debate about what a humane, sustainable social care service should look like.

According to StatsWales, social services Welsh spending on the over 65 year age group has increased from £485 million in 2008-09 to £547m in 2015-16. This is obviously much better than the 8% real terms cutbacks in England over recent years (Institute for Fiscal Studies) However this good relative picture cannot disguise the urgent need for more investment in social care in Wales.

This investment is not only needed to address issues of the quantity of service need but also of quality and priorities. We need a clear view of what should be addressed first and what are the relative importance of other factors.

Meet current unmet need.
Between 2006-07 and 2015-16 the number of 65 years+ people receiving social services declined by about 15% (Stats Wales). However the 2016-17 return saw an annual increase of over 20% to 62,500 people (based on incomplete returns). But this report was compiled in line with the changed requirements of the Social Services and Well-being (Wales) Act 2014 so it is not possible to fully compare like with like. It therefore remains very likely that fewer people are receiving care despite the increased ageing of our population.

There is no strong evidence that fewer people are being referred to local authorities for assessment so it is likely that eligibility criteria and social care practices are being changed in line with budget availability with the result that fewer are actually getting publicly funded services.

The 2016-7 Stats Wales returns show that there were 70,303 assessments of need undertaken which led to the provision of 20,886 care and support plans i.e. just under 30% of those who asked for an assessment.

This figure again has to be understood in the context of the the Social Services and Well-being (Wales) Act 2014. This requires that once an assessment decides that a care and support package can meet a person's 'well-being outcomes' a further decision has to be made on whether these needs can be 'sufficiently met' by support coordinated by the clients themselves, their family or carer, or by community-based providers. Only if this is not the case will the local authority provide the service.

The new National Assessment and eligibility guidance will therefore mean that public provision will only be available to the most vulnerable of our citizens with the most difficult and complex needs. This increases the scope for many more potential beneficiaries to fall through the care net not least because they have neither the means or the support network to respond to the identified levels of need.

Meet growing need
Demographic changes and the ageing of our population will inevitably mean that need for social care will continue to grow. However anticipating how big and fast this growth will be

is difficult not least as the boundaries between health and social care are becoming increasingly blurred in people who suffer from conditions such as dementia or who are frail and vulnerable due to a range of multi-system disorders.

Conventional wisdom would have us believe that we have to manage a ticking demographic time-bomb. By 2041 the number of people age over 65 is expected to increase by almost 37% with the most dramatic increase is expected for people aged 85 and over – a 119% increase. This is against a backdrop of Wales already having a higher proportion of people aged over 85 than the rest of the UK (Social Care Wales National Assessment Report 2017). It has been suggested that this could lead to an increase of over 50% in the demand for domiciliary care services and over 60% increase in the need for residential care.

However people's greatest demand on health and social care is not strictly related to age itself. Instead services are most intensively used in the last few years of life whenever that takes place. And so when we take increased life expectancy into account then the need for services could become relatively less as the population gets older.

Dr Allyson Pollock has pointed out that despite an ageing population, demographic changes have so far accounted for a relatively small proportion of the increase in spending on health care in the UK. While overall spending (between 1965 and 1999) grew by 3.8 per cent a year in real terms, the demographic changes alone required annual real terms growth of just 0.5 per cent a year.

There will be some absolute increase in demand as the size of the older population increases but depending on the health and well-being of an older population it is possible that need may be less than the most pessimistic predictions would have us believe. But to achieve this desirable outcome we must invest in a healthy ageing strategy now.

The costs of an ageing population cannot only focus on expenditure in health and social care. We must, as both the Social Services and Well-Being (Wales) (SSWB)Act and the Well-being and Future Generations (Wales) (FGWB) Act 2015 require, include provision to promote prevention and early intervention so that as we live longer lives, older people will be healthier, happier and more independent. Here, the provision of adequate housing, including the role of different forms of sheltered housing, needs to be ensured.

Many of the services that will allow this to happen are not provided on a statutory basis by our public bodies and have been in the front line of the austerity cut-backs. The harsh reality of austerity means that the general statutory duties included in recent Welsh Government legislation are being ignored in the face of other priorities. Unless this is acknowledged and reversed we may find the demographic time-bomb becoming a reality.

Reduce barriers between health and social care.

The National Health Service Act was passed in 1946 and provided for a free, universal health service. In 1948 the National Assistance Act repealed legislation that extended back to Tudor times. It gave responsibilities to local councils to provide services, particularly residential, for older people and they were empowered to levy means tested charges. Over time these duties greatly expanded to include community care services but means testing remained unchanged.

The difference between a “free at the point of service” NHS and means / eligibility tested

social care is a massive practical and confusing barrier between the services that begins at Welsh Government level. Different national standards have developed in the two services and there are substantially different professional cultures. As well they are often competing for funding streams as resources are channelled separately to local health and local authority social care organisations. The challenge of creating integrated health and social care is therefore difficult, complex and begins at the very top of government. It goes much wider than removing organisational barriers as the experience in Northern Ireland shows.

These divisions have also led, at times, to the unedifying spectacle of two publicly funded public bodies slugging it out in expensive litigation to decide which of them should pay for the care for highly vulnerable citizens.

A vulnerable person may have a range of needs which do not readily fit into a social care or health / nursing care categorisation. Reflecting this ambiguity a small scale industry has emerged which is involved in arguing for fairly arbitrary care decisions which make no sense to the recipient. No matter how justified separating “health” and “welfare” might have seemed in 1948, it no longer makes sense if we wish to deliver integrated, humane care.

The SSWB Act has placed a duty on local authorities to collaborate with their relevant partners. But the same does not apply to the NHS. SHA Cymru therefore warmly welcomes the Welsh Government's plans to address this major omission as outlined in its white paper, “Services Fit for the Future”.

These statutory duties and responsibilities must be driven forward though a range of initiatives including the Regional Partnership Boards. These boards must continue to evolve and wield real power, under-pinned by statute, to bring health and social care together though joint planning and the creation of unified, needs-based budgets. The policy intention of integrated services must have delivery and governance structures in place to ensure that they become a reality for service users.

These initiatives must cascade down though health boards and local authorities to front-line delivery bodies such as primary care networks and primary care teams. Hopefully the recently announced substantial investment of £68m into health and care centres /hubs will provide important impetus and produce evidence of what works in the Welsh context. It is vital that these lessons are quickly mainstreamed into everyday core provision as the final report on the Parliamentary Review on Health and Social Care strongly urges.

The Welsh Government must set a clear statutory timetable in place for the full integration of the planning and delivery of health and care at a local level. We can look to the experience in Scotland to see what can be learned from their “integration joint boards” and from the plethora of, often regrettably fragmented, experimentation that is taking place in England. Structural re-design may be only one element of a programme for integration; changes in professional cultures and creating different means of “spanning” both organisational and professional boundaries is essential. Research arising from network theory may also be instructive.

SHA Cymru also welcomes the Welsh Government's commitment to joint complaint procedures and advocacy where over-lapping of health and care services take place. The continuing unedifying experience over “who pays” for certain elements of care should not continue to be perpetuated in a complaints process with endless semantic arguments over “who is responsible”. This denies services users or their families proper redress and

prevents valuable lessons being learned when things go wrong. It is also important that external service regulators and inspectors work in an integrated way to deliver coherent overviews on quality assurance from a user and citizens' point of view as outlined by “Services Fit for the Future”.

Joint-working in Wales has grown apace since the launch of the Making the Connections agenda in 2006 as highlighted by a recent publication by the Welsh NHS Confederation (Health and Social Care - Celebrating Well-being: A selection of case study examples). Programmes such as the Integrated Care Fund have produced many excellent examples of what can be achieved including the reduction of delayed transfers from hospital care by almost one third in the last decade compared to the continuing increase in England (House of Common Library; Health and Social Care Integration 2017).

But it is important that integrated health and social care should not be seen just in terms of reducing the pressures on the expansive acute hospital sector. It must be firstly about delivering better outcomes for service users.

Social justice & social contract

Many people believe that social care is paid for through public agencies on a similar basis as the NHS and that their taxes and national insurance contributions go to achieve this (Citizens Advice Wales 2016). They are bitterly disappointed when they are confronted with the reality that social care is means tested. Andrew Dilnot described the means testing of social care as “the most pernicious means-test in the whole of the British welfare state”.

Most of the people who require expensive social care have worked hard to save, paid their taxes and social insurance and hoped to leave a legacy to their future generations only to find that their care needs swallows up what they have saved.

There is evidence that many people who would have to pay for a service either refuse a financial assessment (and so get no service) or do not take up the service when they are aware of its cost and what is involved. Dame June Clarke states, in her 2017 Jack Jones Lecture, that many are not prepared to go through this complicated and demeaning process of “baring their all to a stranger” whose interest, at times, is best served by denying their application.

In any year, on average, less than 10% of the over 65 yrs old population will be in receipt of social services. Within that group the scale of need is unpredictable at an individual level and over time. Based on English evidence it has been estimated that one in ten people could face social care bills in excess of £100,000 with a 70% loss of assets for those with a median income and assets if they require five years of residential care.(Dilnot 2011). While most who move to a residential or nursing home do not live for more than 1-2 years, about 20% survive for three years and more (Older Peoples' Commissioner Literature Review 2014).

There is no reason to assume that Wales is substantially different. This cost of care is prohibitive for all but the super-rich.

Social solidarity based on pooled risk provision for the whole population therefore seems appropriate --- covering both the rich, the comfortably off and the poor --- for services being delivered on the basis of need. This service should not be paid for at the point of

need but through a more socially just, progressive taxation programme.

Priority between community and residential care.

There seems to be a consensus that virtually everyone would prefer care in their own homes and their own community rather than in a residential setting. SHA Cymru would not disagree with that. We are therefore surprised that there is little evidence from StatsWales of a significant increase in the number of “homecare” hours (12.5 million – 13.5 million) being provided through local authorities over the last decade or in the numbers of clients receiving home care (39.3000 in 2015-16; 46.800 2005-06). And over this time there was a 20% reduction in adults over 65 yrs supported in care homes. This again seems to show that financial pressures are taking precedence over meeting care needs and policy priorities.

We need funding mechanisms that avoid the perverse incentives that litter our present care system. Continuing NHS care is free while social care is means tested. In some instances domiciliary care will avoid more expensive residential care costs and people may stay inappropriately at home. In other cases, if residential care costs are more easily paid for, there may be less enthusiasm to support service users staying in their own homes and in the community.

SHA Cymru has concerns that the balance between community and residential care is not always driven by service users' wishes or needs but is dictated by financial pressures. Generally community care is thought to be a less costly option and consequently residential care places are being lost in response to austerity. It is therefore essential that the statutory needs assessments that are now required accurately reflect the relative balance between community and residential care and that this informs future service planning in a transparent and honest way.

Staff recruitment, retention and training.

Too much of social care is delivered by under-valued, under-paid and under-trained staff. Quality of care has its own premium and we must, as a caring society, be willing to pay for it. Future funding must acknowledge the need for this quality premium.

Unison, the public sector trade union, has been highlighting this problem for many years. Its 2012 survey found that 79.1% of home care / domiciliary workers reported that their work schedule is arranged in such a way that they either have to rush their work or leave a client early to get to their next visit on time. 56% of workers received between the then national minimum wage of £6.08 an hour and £8 an hour and 57.8% were not paid for their travelling time between visits. A key part of the Unison's response to this survey was to call for an Ethical Care Charter which would include the end the practice of the “15 minute visit” which undermines both the dignity of care recipients and care workers. When the University of Greenwich undertook an evaluation of the charter at the end of 2016, only one local authority in Wales had signed up to it.

In the Labour Party's UK General Election Manifesto in June 2017 it acknowledged this need and pledged to provide an addition £1billion of funding in its first year in power to support the implementation of the Ethical Care Charter.

A Resolution Foundation study (2013) found that the care worker sector in the UK was one that has low levels of formal qualifications --- 37% of adult direct care workers hold no

qualifications and 61 % only hold Level 2 qualifications or below. It felt that this reflected the fact that historically care has been provided informally by women within the family and, as such, remains low-status. Eighty four per cent of domiciliary care workers are women and many are motivated by job satisfaction and the emotional rewards of care work rather than financial gain.

The Welsh Government had indicated its wish to see domiciliary care workers being registered with Social Care Wales by 2020. Such registration will improve the standing and status of care workers but there will be an inevitable resource implication as the registration programme proceeds. In view of the progress to date the 2020 registration target still seems very ambitious.

Public sector austerity is imposing downward pressure on the fees paid to care homes and providers which is compromising their capacity to achieve a dignified quality provision. This is compounding a staffing crisis as this low paid sector finds itself even less attractive compared to other potential employers in a growing low wage economy. Not only is difficult to recruit staff there is also a high level of staff turnover due to the poor employment practices, long irregular hours, poor career structure, absent training as well as casual and zero-hours contracts. An end to the public sector pay cap must be the first step towards ending this totally unsatisfactory and unstable situation.

The Older Persons' Commissioner has also pointed out that problems exist in retaining quality managers and nursing staff. There is a discrepancy between the nursing standards in the NHS and in the care home sector. This can be due to a number of factors, including limited clinical supervision, a lack of peer support in nursing homes and a lack of opportunities for professional development.

And as the first report of the Parliamentary Review on Health and Social Care in Wales pointed out, a hard Brexit could make the situation worse for the sector that is heavily dependent of a migrant workforce.

Public / private mix

For decades more and more social care has been provided by the “for profit” sector. In the domiciliary care sector the proportion provided by the independent private providers has increased from just over 50% to over 80% in the last decade and it also provided 78% of residential care places (StatsWales). Much of this shift was driven by a combination of ideological dogma that “private is good, public is bad” and by so-called value for money assumptions that cheaper private sector provision is preferable to the “wasteful” “poor value for money” and “expensive” public sector.

The “for profit” sector is a combination of smaller individual providers and ever bigger corporate bodies. Their “better value” is largely at the expense of their work force's wages, terms of service and training as well as the fees that it charge its residents.

In its submission to the National Assembly's Health, Social Care and Sport Committee's investigation of the health and social care workforce Unison pointed out ...“ it is clear the marketisation of social care has failed.... Care services need to be delivered directly by the local authority. The terms and conditions of social care workers employed directly by a local authority are far more favourable than their counterparts in the third or private sector. It is worth noting that where staff are employed directly by a local authority, staff turnover is far lower.”

PricewaterhouseCoopers (2013) concluded that, amongst a range of other factors, smaller providers in converted buildings were more vulnerable to the pressures facing social care providers. But as the 2011 collapse of Southern Cross and the on-going issues at the Four Seasons Group show, even larger corporate providers are far from immune.

Direct Payments / Personal budgets

SHA Cymru is concerned that service users do not always get the personalised, flexible care that they require. In some cases social services can be too bureaucratic, too big or cumbersome in the way they deliver a service. Equally there can be instances in which a service user and social services cannot agree which is the best package of care. If social services insist on providing a service in a way that is not "user centred" it may be refused or result in sub-optimal outcomes which will deprive a vulnerable citizen of their entitlement and deliver poor value for money.

In an attempt to address this over recent years the Welsh Government, though the SSWB Act , has been actively promoting individual payments / personalised budgets. As a consequence the number of users of direct payments has almost doubled to over 2,000 people. While SHA Cymru believes that personalised budgets have a role to play for certain types of service they should be seen as having a limited niche role rather than being promoted as a preferred care option.

In practice individual payments do not deliver individualised services. People are not offered direct flexible support, instead they are encouraged to take their budgets as cash and employ your own staff, even when this is burdensome. The situation is further complicated by the local authorities' continuing duty to ensuring that the recipients needs are being met.

Individual payments create their own unnecessary risks, costs and bureaucracy for patients and care providers. They are a further step away from public provision towards creating a market in care which frequently requires people to personally manage a budget and employ their own staff with all that that entails in terms of employment law. Extra support is provided to the service user to help them carry out these tasks but this will involve the use of resources that will have been diverted from front line provision.

In addition direct payments risk undermining pooled-risk, public service provision. Most individual payments are funded on "the average cost" basis. In practice most additional public services are provided at a marginal cost which is usually less than the average cost. As a consequence a big increase in the use of individual payments could reduce the overall sum of money available to the majority of service users.

Funding Models

As well as looking at the areas where funds are needed and what our priorities are we need to consider wider funding models.

Social care delivery in Wales is subject to a means test for both domiciliary and residential services. This is based on an financial assessment which looks at an individual's income and assets including the value of their home so long as they have no resident dependents.

Over the years the income and asset "disregard" has increased and it is more generous in Wales than in England. From April 2017 the Welsh Government increased the capital limit to £30,000 (increasing to £50,00 by end of this Assembly term) for residential care, but

opted to keep it at £24k for non-residential services. In addition in Wales there is a cap on the weekly cost of domiciliary care unlike in England. The current maximum charge from 10 April 2017 is £70 per week. As well service users can choose to opt to retain their assets in return for a charge or deferred payment to recover costs when they pass away.

In practice this means that about 80% of residential care homes residents and 44% of domiciliary care recipients (LE Wales 2014) are not charged for the services they receive. This has led some to argue that any radical change to the present system will only favour the rich and better off.

However many who pay for care have modest incomes and can face difficult financial choices until they reach the "disregard" thresholds. These choices are most difficult for those on middle level of incomes who have little scope to manipulate their financial affairs like the super-rich. It is important that public policy in Wales takes the needs of this group into account rather than focus on "anomalies" that might arise about free care for the 0.4% of the Welsh population who are millionaires. In these circumstances it is more important that a greater priority is given to tackling tax evasion by the super-rich and promoting a more progressive tax regime to support socially just public policies.

A recent report by the Older People's Commissioner (2014) said " ...the current lack of knowledge about the number of self-funders in Wales living in care homes has an impact on the quality of life of older people as it is not clear what support and advice individuals are receiving and the extent to which or how the quality of care that self-funders receive is monitored." This is neither fair or socially just.

It is inevitable that promoting a more socially just care policy will involve greater public expenditure. The 2017 Labour Manifesto promised to increase spending on social care by £8 billion in the next Parliament. On the other hand David Cameron, in response to the Dilnot Commission's recommendation of a £35,000 cap on care costs, proposed to implement a £75,000 cap by 2020. The Tories' subsequent chaotic proposals for a "dementia tax" at the last general election in 2016 showed that how confused their thinking is on this matter. The best we can now hope for from the UK Government is a green paper on care and support for older people by the summer 2018. This, it is claimed, will set out plans for how it proposes to improve care and support for older people and tackle the challenge of an ageing population.

A number of solutions, some more realistic than others, have been proposed to address this including:-

- Continue to increase the level of income and asset "disregards". There could be variations in how this could be achieved e.g. exclude domestic homes from asset assessments or only take the average domestic home costs into account.
- Further reduce the maximum payment cap for domiciliary care.
- There could also be a maximum cap placed on residential care costs. This could be done on a weekly, annual or lifetime basis. Labour Party General election manifesto favoured this option.
- Provide a support payment against costs. This payment could be linked to the actual level of costs or level of income or a combination of both.

Some of these options would be feasible for the Welsh Government on the back of "Barnett consequentials" if public expenditure was to rise in line with the Labour's manifesto commitments.

SHA Cymru's favoured solution is a universal needs based service free at the point of use. In view of the cost involved it would not be possible to achieve this without a comparable initiative in England through the operation of the Barnett Formula or, even better, though a needs based funding transfer.

In recent years the Welsh Government has commissioned LE Wales to undertake a number of studies looking at the cost of various care options including providing free social care. It estimated that the 2013 cost of residential care was £238 million and that an additional £213 million would be needed to provide free residential care for those who were over-65 years old.

In the run up to the 2017 National Assembly elections Plaid Cymru came up with a plan to phase out all social care charges over a 10 year period. Plaid estimated that the cost of getting rid of getting rid of non-residential fees would be £32 million. So the total cost of a package to end all charges for those over 65yrs could be of the order of £245 million.

In Scotland social care funding is divided into continuing personal care costs and living costs. In July 2002 the Scottish Government introduced a policy of free personal care for those over 65 years at the cost of £107 million in the initial partial year, £143 million in the following full year with this sum increasing to £169 million in 2008 (Independent Review of Free Personal Care and Nursing Care in Scotland; Lord Sutherland Report 2008). It found that the biggest area of care growth over the first three years was a 60% increase in domiciliary care services.

Now the Scottish local authorities pay £171/ week to providers of residential care with an additional £78 for nursing care with residential or "hotel" costs being met by the service user themselves. A means test is used to fund full "hotel" costs of those with assessable assets of less than £16,250 with an upper assistance limit of £36,250. For those in receipt of full support there is a payment of £648.92 per week for nursing care (October 2016 - April 2017) and £558.71 per week without nursing care. So while personal social care is free in Scotland, residential care service users will still pay for living costs if they have assessable assets of more than £16,250.

When free personal care was introduced in Scotland the Attendance Allowance continued to paid for those in receipt of free domiciliary care but it was withdrawn from those who had free residential care thus saving the UK Government £25-30 million annually. This proved to be controversial at the time and there is still a campaign to have the Allowance restored for those in residential care which would reduce the cost of free personal care for the Scottish Government.

By 2015-16 78,000 people in Scotland benefit from Free Personal and Nursing Care with just under 31,000 of these people living in residential homes and around 47,000 receive domiciliary care. Domiciliary care now costs of £371 million. This is an increase of about 60% from the 2006-7 costs with the cost of residential care remaining largely static (Scottish Government 2017).

Over the years a range of other options have been offered to address the growing costs of social care short of a universal service funded from general taxation.

The Dilnot Commission (2011) suggested a lifetime cap of £35,000 on social care costs at a cost of about £1.7 billion with lesser payments based on means testing. In addition, depending on their means, people would also contribute to their living costs to a limit of

about £7-10,000/year.

The Barker Report (2014) proposed a greater amalgamation of all older people's spending including health, social care and social security to provide an enhanced social care service linked to increase public expenditure of £5 billion largely funded from increased national insurance payments and a wider review of taxation.

None of these options, or others that are less well-known, are deliverable solely within a Welsh devolution framework that is likely to exist in the immediate future. Changes will have to take place at a Westminster level to provide both the legal framework and the finances to allow progress.

In the more short term there is a case to consider the devolution of “older people's” benefits and public expenditure to the National Assembly. This would provide the Welsh Government with a greater level of resources and allow it to plan more imaginatively for the future of our older citizens. However there are pitfalls not least as a Tory Government might be willing to devolve the legal responsibilities linked to a continuing austerity budget.

Conclusion.
It is inevitable that the cost of caring for an older population will increase. In part this will be driven by demographic factors and by efforts to reduce the costs of the acute hospital care sector. These are legitimate objectives but they must not dominate our vision.

The Welsh Government has a range of policies and legislation in place that could provide older people with the prospect of more dignified, autonomous and higher quality lives. But in too many areas “intent” is not the same as implementation.

Already “austerity” and neo-liberal economics have undermined both the quality and quantity of services that people receive. It has also blurred the vision and blunted the ambition that we deliver a radically better future for our older citizens. Only a new commitment to policies underpinned by the principles of social solidarity and justice will allow us to achieve this.

Contact details

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Secretary SHA Cymru Wales

Yn cefnogi pobl â cholled golwg
Supporting people with sight loss

Response to National Assembly for Wales Inquiry into the Cost of Caring for an Ageing Population

1. Introduction

RNIB Cymru is Wales' largest sight loss charity. We provide support, advice and information to people living with sight loss across Wales, as well as campaigning for improvements to services and raising awareness of the issues facing blind and partially sighted people. We support, empower and involve thousands of people affected by sight loss to improve lives and challenge inequalities.

We welcome the opportunity to provide evidence to this Inquiry into the Cost of Caring for an Ageing Population and will use this opportunity to highlight the needs of blind and partially sighted people. We hope that the recommendations that emanate from this inquiry will provide greater consideration to future social care needs and related costs of an ageing population. Being blind or partially sighted can affect every area of your life and there are many different conditions which someone may develop in later life which are either related to their sight loss or need to be considered as people will need additional assistance in coping with such conditions and their sight loss.

Many areas of the health and social care service in Wales are struggling to cope with or do not fully recognise the links between conditions and sight loss or the impact of sight loss on those conditions. There is a large capacity issue within the eye care service and RNIB Cymru has been working with Welsh Government to try and find solutions. In this area in particular, it is likely that demand is going to increase hugely with the ageing population and thus the cost of health and social care.

2. About sight loss

There are approximately 107,000 people living with sight loss in Wales [1]. 8,400 people are registered severely sight impaired and almost 8,600 are registered sight impaired [2]. Every day in Wales, nearly 4 people start to lose their sight [2] and one in five people will live with sight loss in their lifetime [3].

The risk of sight loss increases with age and 1 in 9 people over the age of 60 is living with sight loss, which rises to 1 in 5 people aged 75 or over [1]. With an **ageing** population, the number of people with eye conditions is projected to rapidly increase over the coming years and by 2050, it is estimated that the number of people living with sight loss in Wales will double [1]. With this demographic shift come new challenges, with more older people needing support to live with sight loss and more experiencing sight loss alongside other challenges associated with age.

Sight loss has a huge impact on individuals. For many people, loss of sight results in increased dependence on others [4]. In a survey of blind and partially sighted people conducted by RNIB, 60 per cent of respondents stated that they needed help to get out of the house because of their sight loss [5]. Nearly half of blind and partially sighted people report feeling ‘moderately’ or ‘completely’ cut off from people and things around them [6], with 43 per cent saying that they would like to leave their homes more often [7]. This sense of isolation inevitably has an impact on people’s mental and emotional wellbeing.

3. Estimated number of people with sight loss by 2050 and related health and social care costs

The projected estimate for the number of people with sight loss in the UK in 2050 is 4,145,000. This is approximately 218,000 people in Wales [1]. Although sight is the sense we most fear losing, as a society we spend relatively little to prevent, detect and treat eye disease.

Government also spends relatively little on health and social care services to support independent living by those with sight loss. Key services such as rehabilitation, social support, community

equipment, disability benefits, and accessible transport are generally under-funded and under-developed.

Vision rehabilitation services are crucial to ensuring blind and partially sighted people remain as independent as possible. Now, new independent research commissioned by RNIB, with support from the Department of Health, has identified that the cost of providing vision rehabilitation services is dwarfed by the financial benefits [8].

Independent research by the Office for Public Management (OPM) and based on a case study of services provided by Sight for Surrey has shown that the financial benefits of good vision rehabilitation services significantly outweigh the actual costs of delivering this service. In fact, in the case study site, over £3.4 million of health and social care costs were avoided, reduced or deferred annually based on a service which cost an estimated £900,000 a year to deliver [8].

The **Social Services and Well-being (Wales) Act 2014** in particular provides the statutory framework to deliver the Welsh Government's commitment to transform social services in Wales to improve the well-being of people who need care and support and carers who need support. The Act sets out a definition of well-being for people who need care and support. Everyone, adult or child, has the right to be heard as an individual to shape the decisions that affect them, and to have control over their day to day lives.

Financial pressures in healthcare services are further compounded with the direct healthcare cost linked to eye health estimated to be at least £151.1 million every year. This includes NHS healthcare expenditure [1]. So this is money spent on preventing and treating eye conditions. Indirect costs associated with sight loss due to lower employment rates and unpaid care provision cost the Welsh economy around £268 million* every year. [1]. Furthermore, it is estimated that the associated reduction in wellbeing and health due to living with sight loss totals £1 billion every year in Wales [1].

(*this figure includes estimates for Lower employment, Absenteeism, Premature mortality, Informal care costs, Devices and modifications, Deadweight loss. It doesn't directly include social care benefits.)

In addition to paid health and social care provision, there is also a cost to unpaid carers. The Office for National Statistics (ONS) now regularly publishes estimates of the value of unpaid household services in the Household Satellite Account [9]. The data examines the value and division of that unpaid household work using time use data and presents estimates of the amount and value of informal child and adult care with analyses by sociodemographic variables including sex, age, and labour market status.

Information from the ONS census provides a cost to care provided by unpaid carers at an estimated value of time and the cost of providing this unpaid adult care is £7.97 billion [9]. This would further increase with an ageing population.

The **Well-being of Future Generations (Wales) Act 2015**
The Well-being of Future Generations (Wales) Act 2015 came into force in April 2016. The Act requires public bodies, including the Welsh Government, to think more about the long-term, to work better with people, communities and each other, look to prevent problems and take a more joined-up approach – helping to create a Wales that we all want to live in, now and in the future.
This is intended to support an integrated approach to public service delivery, and a focus on giving people and communities a voice in how their services are provided.

4.Conclusion

Sight loss is closely linked to ageing, and as the number of older people is set to rise dramatically, so will the number of blind and partially sighted people. People in later life face unique challenges as, in addition to sight loss, they are also more likely to have additional health problems such as loss of hearing, reduced mobility and dementia. Increases in sight loss as the population ages will serve to increase pressures on the health and social care system and NHS and social care expenditure.

Current Welsh Government policies including recent social services legislation and reforms to social care funding on local authorities, care providers and service users, will need to be considered in the costs of caring for an ageing population.

References

1. Pezzullo L, Streatfield J, Simkiss P, and Shickle D (2016) The economic impact of sight loss and blindness in the UK adult population. RNIB and Deloitte Access Economics. Manuscript submitted for publication.

2. Stats Wales (2017) https://statswales.gov.wales/

3. The State of the Nation Eye Health 2017: A Year in Review

4. Slade J and Edwards R, RNIB "My Voice 2015: The views and experiences of blind and partially sighted people in the UK, RNIB 2015

5. RNIB Cymru, "Saving sight and saving money: the cost and impact of sight loss in Wales", 2012)

6. Pey, T, Nzegwu, F and Dooley, G, "Functionality and the Needs of Blind and Partially Sighted People in the UK: An interim report", 2006

7. Douglas, G, Corcoran, C, and Pavey, S, "Network 1000: Opinions and circumstances of visually impaired people in Great Britain", University of Birmingham, 2006

8. OPM Group, Demonstrating the impact and value of vision, RNIB 2017

9. https://www.ons.gov.uk/economy/nationalaccounts/satelliteaccounts/articles/changesinthevalueanddivisionofunpaidcareworkintheuk/2000to2015 [Accessed 29.01.18]

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30th January 2018

Dear Simon,

Re: Finance Committee inquiry into the Cost of Caring for an Ageing Population: Alzheimer's Society Cymru response

1.1 I am pleased to respond on behalf of Alzheimer's Society Cymru to the Finance Committee's consultation on the cost of caring for an ageing population.

1.2 Alzheimer's Society is the UK's leading dementia charity. We provide information and support, improve care, fund research, and create lasting change for people affected by dementia.

1.3 Alzheimer's Society Cymru welcomes the Committee's interest in the financial impact of the cost of caring for an aging population.

Overview

- There are 45,000 people with dementia in Wales, and this is forecast to rise to over 100,000. Around 60% of people in receipt of homecare have dementia, rising to 70% of people living in care homes. The social care crisis is a dementia crisis.
- People with dementia usually have to use costly means-tested social services, instead of free health care services because of the lack of a cure for dementia. They must pay more for support because of their condition. This is the dementia tax.
- Dementia costs Welsh society £1.4 billion every year, the majority (£622 million) is shouldered by unpaid carers. Dementia also has a huge social cost, with 61% of carers saying caring has had a negative impact on their own health.
- Dementia care can cost £100,000+ per person – it could take 125 years to save this.
- We welcome increased funding for social services, but are concerned that this funding will not keep pace with increasing demand in the future.
- We believe there should be a lifetime cap on care costs to protect vulnerable people.
- We are concerned that eligibility criteria for carer support are too high, and are driving people into needing expensive crisis care.
- We would like to work with Welsh Government to better understand their proposals for a social care levy, but any proposals need to be based on principles designed to deliver high quality social care.
- We believe that any reforms to social care finances need to share risk across society, to remove the burden of catastrophic costs on individuals and families.
- Over the long term, we believe the social care sector needs new funding sources or insurance based models of support.
- We welcome the Parliamentary Review's findings, provided there is sufficient funding and support for reform from people who are affected by dementia.

Alzheimer's Society Cymru and social care policy

2.1 Wales is at a crossroads on dementia policy. We have an older population than any of the other UK nations, and the lowest rates of dementia diagnosis; we have very few support workers to help people living with dementia, and there are challenges in ensuring access to diagnosis and services in rural areas.

2.2 Yet in the coming years, we can turn things around. The Welsh Government is developing Wales' first ever dementia action plan. We are already becoming a more dementia-friendly nation. And all the time, research is going on to find breakthroughs which can transform how we perceive and deal with dementia. Now, we believe that we have a historic opportunity to address catastrophic costs for social care that can impact on people affected by dementia.

2.3 Dementia devastates lives. There are currently 45,000 people living with dementia, yet half have not received a formal diagnosis. It is estimated that by 2055 there will be over 100,000 people living with dementia in Wales. Across the UK, we estimate that there will be two million people living with dementia by 2051.

2.4 Alzheimer's Society funds research into the cause, care, cure and prevention of all types of dementia and has committed to spend at least £150 million on research over the next decade. This includes investing in the UK's first dedicated Dementia Research Institute, including £13 million to establish a new dementia research centre at Cardiff University.[1] Until the day we find a cure, Alzheimer's Society will be here for anyone affected by dementia - wherever they are, whatever they're going through. Everything we do is informed and inspired by them.

2.5 The Welsh Government is in the process of developing their first ever dementia action plan. The strategy is likely to have a broad impact on the social care sector which we believe the committee should be aware of when inquiring into the area of funding. The proposals in the consultation on the strategy[2] include proposals that:

- Every newly-diagnosed person with dementia should be offered access to a Dementia Support Worker.
- Introduce a joint health service/local authority "team around the family".
- 75% of health care staff should be trained in "Good Work: Dementia Learning and Development Framework".
- Population assessments should include care and support needs of older people with complex needs (dementia).
- Monitoring carers being offered assessments and support plans.
- Local Health Boards and Councils to facilitate access to carer education.
- Ensure social care has pathways in place so that community assessment and ongoing management services are responsive.
- Develop training and learning resources for the social care workforce based on the principles of the 'Good Work' framework.
- All relevant health and social care professionals, including care home workers, should be trained and supported to help people and their family/carer think about end of life care and develop care plans.
- Increasing numbers of Dementia Friends and Dementia Friendly Communities.

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[1] Cardiff University (2017) *£13m dementia research centre*, date accessed 26/01/2018.

[2] Welsh Government (2017) *Together for a Dementia Friendly Wales 2017-22: consultation document*, Cardiff: Welsh Government.

2.6 **T**here is a great deal in the draft strategy which we strongly welcome, and it is heartening to see dementia being recognised as "*one of the most significant health and social care issues we face*"[3], costing Wales in the region of £1.4bn per year[4]. We also welcome the Committee's inquiry into the issue of social care funding as one of the utmost importance for members of the "aging society" who are affected by dementia. However, as part of this inquiry we would urge the Finance Committee to recognise that we should welcome that people are living longer and recognise the contribution of older people and people with dementia to Welsh society. Older people bring value to Wales, enriching our worth as a nation. Negative stereotypes of older people and people with dementia demean and stigmatise people. Older people make important financial contributions to Welsh society - in 2010, over-65s made a net contribution of over £1 billion to the Welsh economy, equating to nearly £3 million every day[5]. This should not be forgotten as part of this inquiry and we concur with the Older People's Commissioner on Wales' comments on this issue.[6]

2.7 We have also supported people affected by dementia to share their stories with the National Assembly for Wales' Health, Social Care and Sport Committee during their inquiry into the draft dementia strategy and during two meetings of the Senedd's Cross-Party Group on Dementia, to inform responses to this consultation. Through this, a range of people affected by dementia from across Wales had an opportunity to contribute their views on the proposals and we hope both of these groups will have benefited from hearing first-hand the experiences of people affected by dementia, and will use this to inform their scrutiny of the dementia strategy. We would be happy to support Finance Committee on a similar evidence gathering exercise to hear from people affected by dementia what they would want to see in terms of social care funding reform.

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[3] Welsh Government (2017) *Together for a Dementia Friendly Wales 2017-22: consultation document*, Cardiff: Welsh Government.

[4] Alzheimer's Society (2015) *The Hidden Cost of Dementia in Wales*, Cardiff: Alzheimer's Society.

[5] WRVS (2011) *Gold Age Pensioners: valuing the socio-economic contribution of older people in the UK* (Welsh summary document), Cardiff: WRVS.

[6] Older People's Commissioner Wales (2017) *Commissioner: Disappointing that Committee Inquiry could reinforce ageist attitudes*, date accessed 25/01/2018.

The current landscape of dementia and social care funding

3.1 There is an enormous injustice in the care system for people with dementia – the Dementia Tax. Dementia is currently a condition with no cure and people who develop it receive most of their support from the government from the social care system, not health care.

3.2 Dementia is a complex condition and the impact of symptoms can make it increasingly difficult to carry out the everyday tasks most of us take for granted, like washing, eating or using the toilet. Someone with dementia may require one to one support with nearly every aspect of life, either at home with a homecare worker or in a care home. This is classed as social care, rather than care provided free on the NHS. Social care is means-tested and therefore costly.

3.3 For many other long-term health conditions, such as cancer and heart disease, medical treatments are available for free on the NHS. However, these treatments don't yet exist for dementia, meaning that it is costly social care, as opposed to free treatments, that people with dementia are forced to pay for. It should not be the case that because you develop one condition over another, you can be left bankrupted by care costs. This is not a fair system and Alzheimer's Society has been calling for an end to this 'dementia tax' for the last ten years.[7]

3.4 Being diagnosed with any condition can be challenging and stressful, but in the current system people with dementia are facing the added worry of financing their care, which could cost thousands of pounds. We believe this system is unequal and needs overhaul. Regardless of the condition you have, you should have the same access to high quality and affordable care, including for people with dementia. People with dementia should not bear the sole responsibility for saving and paying for their care.

3.5 We believe that dementia can be the channel through which to achieve social care reform. We know that around two thirds of recipients of homecare or care home residents have dementia.[8] This means social care crisis is therefore a dementia crisis. When the social care system is restricted or provides poor quality care, it can have a devastating impact on people and on the wider health system. We believe that building a social care system that is better for people with dementia will improve the system for everyone.

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[7] Alzheimer's Society (2017), *Dementia Tax*, date accessed 20/01/2018.

[8] Alzheimer's Society (2007), *Home from Home: A report highlighting opportunities for improving standards of dementia care in care homes*, London: Alzheimer's Society.

Patterns in demand for social care services for those of pension age, and the related costs of delivery of residential and non-residential care.

4.1 The social care crisis is a dementia crisis. Prevalence and diagnosis rates for dementia are increasing and with it, demand for social care services to support those people affected by dementia. The costs for people affected can be catastrophic, and informal carers are often relied upon to provide unpaid services. People with dementia depend on the costly social care system for essential support

4.2 We know that there is increasing demand for social care, in particular services for people with dementia. There are currently around 45,000 people living with dementia in Wales; this is estimated to increase to over 100,000 people by 2055.[9]

4.3 More and more people are developing dementia as Wales' population ages – age being a key, but not the only, risk factor for dementia. It is anticipated that by 2022-23, people aged 65 and over will account for over 22% of Wales' population - up from around 18% in 2009-10.[10] Over the next 20 years, the percentage of people aged over 65 in Wales is set to increase to around 25% of the entire population. The population aged over 75 in Wales is also projected to increase from 9% of the population in 2014 to around 13% in 2030.[11] There is a projected increase in the number of people aged over 65 in Wales by almost 37% by 2041, while there is a projected increase in the number of people aged over 85 of 119% by 2035.[12] Wales has a higher proportion of people aged over 85 than the other UK nation.[13]

4.4 At present, the diagnosis rate for dementia in Wales is around 51% – the lowest of any UK nation – but the Welsh Government's Dementia Action Plan sets out an ambition to increase the rate by at least 3% annually, reaching 66% by 2021. With both prevalence and diagnosis increasing, it is clear that people affected by dementia will form an even larger proportion of people using social care services in the future.

4.5 Supporting people with dementia is further complicated by comorbidities - secondary or other conditions which people have at the same time as dementia. Some common comorbidities are depression, diabetes, hypertension, falls, fractured hips or hip replacements, urinary or chest infections, chronic obstructive pulmonary disorder, musculoskeletal disorders and chronic cardiac failure. People living with dementia who are over 65 have on average four comorbidities, while people without dementia have two on average.[14] Research has shown that untreated comorbidities of people living with dementia cost UK health care at least £993m annually, covering three main comorbidities of £377m due to diabetes, £115.7m due to urinary infections and £501.7m due to depression.[15] These co-morbidities mean even higher pressures on the health and social care system as "people with dementia and comorbidities are more likely to be hospitalised, have longer admissions, and incur higher expenditures for their comorbidities than people without dementia" because people with dementia are often "subject to an increased risk of serious delays in the recognition of new or

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[9] Alzheimer's Society (2015) *Diagnose or disempower? Receiving a diagnosis of dementia in Wales*, Cardiff: Alzheimer's Society.

[10] Wales Public Services 2025 (2017) *The future funding of health and older adult social care in Wales*, date accessed 25/01/2018.

[11] Wales Government Future trend report (May 2017) cited in Welsh Government (2017) *Consultation document: Mandatory Concessionary Fares Scheme in Wales*, Cardiff: Welsh Government.

[12] Welsh Government, *National population projections*, date accessed 26/01/2018.

[13] Social Care Wales (2017) *Care and support in Wales: national population assessment report*, Cardiff: SCW.

[14] Poblador-Plou B et al (2014) "Comorbidity of dementia: a cross-sectional study of primary care older patients", *BMC Psychiatry*, cited by Dementia Statistics, date accessed 24/01/2018.

[15] Scrutton, J and Brancati, CU (2016); *Dementia and comorbidities; Ensuring parity of care*, The International Longevity Centre supported by Pfizer, cited by Dementia Statistics, date accessed 24/01/2018.

exacerbating symptoms."[16] This may be down to atypical symptoms, communication issues for the person with dementia, or a lack of adequate training for professionals.

4.6 These factors are likely to drive an increase in demand for social care services by people affected by dementia. Today, at least 60% of recipients of homecare have dementia[17] and two-thirds of people living in care homes[18] with some estimates as high as 80%.[19] The number of people aged 65 and over receiving residential care services is projected to increase by 82% between 2015 and 2035, and the numbers receiving community based services to increase by 67% when 2015 population prevalence is uprated for forecast population growth in older people.[20]

4.7 The costs of this social care provision can be enormous for people with dementia. We know dementia costs Wales £1.4billion per year. This represents an average cost of £31,300 per person per year. £622 million is contributed by the work of unpaid carers of people with dementia; social care costs alone amount to £535 million, whilst £196 million is spent on healthcare costs (of which around £4.6 million in spent on diagnoses).[21] Assuming the breakdown of publicly and privately funded social care costs is the same in Wales as in the whole of the UK, of the £535 million spent on social care for people with dementia in Wales, £212 million is met through public expenditure, £298 million is borne by the individuals directly affected by dementia, and the remaining £24 million is the cost attributed to assessment and care management. £6 million in spent on other costs, including police costs of missing person enquiries, advocacy services and research.

4.8 We are also concerned that the impact on social care is being exacerbated by a shift of responsibility from health care services to social care. While people with dementia and carers will need far more social care services than people with many other conditions, people with dementia and their carers will also need access to healthcare services – yet we hear anecdotally all too often that health care services push responsibility for support away from health and towards social care services. This means that many people cannot access the support they need and instead are forced into more expensive social care, exacerbating the dementia tax and leading to worse health outcomes. This drives further costs for health, as individuals who do not receive appropriate health care services when they need them may then need to re-enter the health system to receive support such as expensive crisis care, and can lead to delayed transfers of care (DTOCs) which increase costs to health services.

4.9 It is not only a financial cost that is borne by unpaid carers of people with dementia. The human cost can be substantial as well – caring responsibilities can be difficult, physically and emotionally, and have a substantial effect on a carer's health and well-being. Our *Turning Up the Volume*[22] report found that:

- Around three in five carers (61%) say their health has been negatively affected by caring for someone with dementia
- 27% of carers for people with dementia feel 'cut-off from society

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[16] Fox, C et al (2014) "The importance of detecting and managing comorbidities in people with dementia?", *Age and Ageing*, Volume 43, Issue 6, pp.741-743.
[17] Alzheimer's Society (2016) *Fix Dementia Care: Homecare*, London: Alzheimer's Society, p.8.
[18] Alzheimer's Society (2007) *Home from home: A report highlighting opportunities for improving standards of dementia care in care homes*, London: Alzheimer's Society, p.iv.
[19] Alzheimer's Society (2013). *Low Expectations: Attitudes on choice, care and community for people with dementia in care homes*, London: Alzheimer's Society, p.9.
[20] Data sourced from the Daffodil care data archive, cited in Ogle, J and Trickey, M (2017) *Can Wales fill the social care funding gap?*, IWA website, date accessed 18/01/2018.
[21] Alzheimer's Society (2015) *The Hidden Cost of Dementia in Wales*, Cardiff: Alzheimer's Society.
[22] Alzheimer's Society (2017) *Turning up the Volume: unheard voices of people with dementia*, London: Alzheimer's Society.

- 37% of people caring for someone with dementia that we spoke to report that doing so has affected their personal relationships and social life for the worse.
- Just 17% agree with the statement 'there is enough support available for those who care for people with dementia'. However almost two-thirds (65%) disagree, with 31% saying they strongly disagree.

4.10 The costs for an individual can be enormous and we know they worry people affected by dementia. People are largely unprepared for the challenges of meeting the hidden costs of care. Our research *Turning up the Volume*[23] found the following:

- We estimate typical dementia costs to be around £100,000 for a person throughout their journey, although can be as much as £500,000.
- It would take someone around 125 years to save for their dementia care costs, if they saved at the same rate as their pension.[24]
- Nearly half (47%) of the UK adults aged between 16-75 years old questioned have not started saving for the care and support they might need in the future.
- A third (37%) of the public agree that before being asked, they had not considered the cost of dementia care and support.

4.11 *Our online dementia tax survey, which was launched on the 6th June 2017 and sent to our supporters on social (which has 2,216 respondents to date), found:*

- 65% of respondents are worried about having to sell their or their family's home to pay for dementia care.
- 55% of respondents believe we should create a fair and balanced system between what the state and the individual pay towards their care, which takes into account their financial situation.
- 79% believe you could face spending everything you have on dementia care.

4.12 Alzheimer's Society undertook polling of the general public in June 2017 following the General Election and in October 2017. This showed overwhelming public support for reform:

- 75% of respondents support the need for an upper limit on care costs to ensure people no longer face catastrophic costs.
- 68% of respondents agree that the government should pay for their care if they develop dementia, which increased 10% since the polling in June post-election (the percentage of people agreeing rose from 58% in the last round).
- When asked about the possibility of losing their home to pay for social care if they developed dementia, 72% felt worried, angry or frightened – representing a rise of 9% since the June polling post-election.
- When asked how they would feel if the Government does not address the issue of social care, 81% said they felt angry, worried or frightened.
- 63% agreed they worry any savings they have could be spent on future care costs and they would have nothing to pass on to their children or loved ones.

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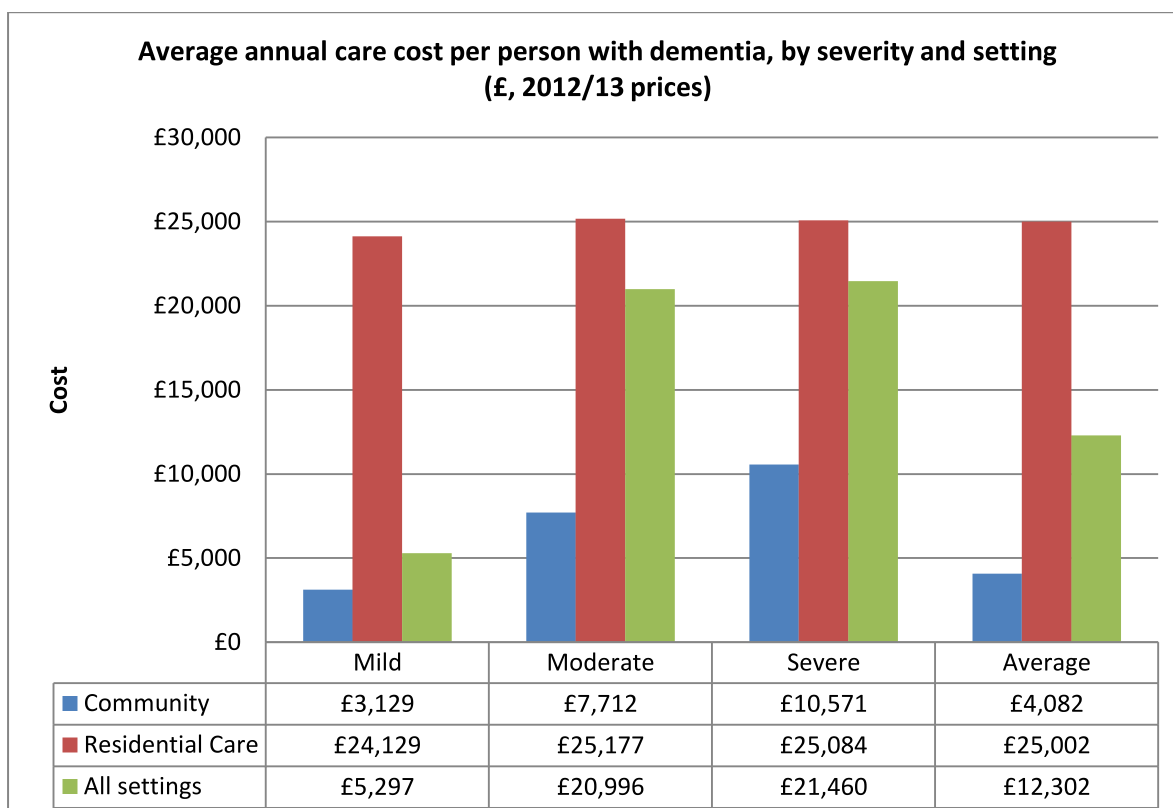
[23] Alzheimer's Society (2017) *Turning up the Volume: unheard voices of people with dementia*, London: Alzheimer's Society.

[24] This statistic has specifically been developed for England, but is likely to be similar for Wales, information available at Alzheimer's Society (2017) *Impossible cost; dementia care bill would take 125 years to save for*, date accessed 25/01/2018.

4.13 We know from IPPR/PwC research[25] that public awareness of social care provision is low. Their research highlights key areas of misunderstanding, such as:

- Funding: only 46% of people involved knew that social care is means-tested.
- Lack of preparation and planning for care needs: only 22% are planning for their care needs.
- Reluctance towards greater family responsibility: 52% believe they should not be compelled to pay for their family's care.
- Support for a more collective, universal system: only 18% are in favour of the current means-testing system.
- A strong will for more debate on the future of the care system: 69% do not feel informed enough about the care system.

4.14 Overall, the picture painted by our research is of a condition that is exacting a substantial human and economic cost in Wales. It is clear that between the £622 million contributed by unpaid carers and the £298 million borne by individuals directly affected by dementia, and the associated negative effect on wellbeing, the impact on an individual with dementia and their loved ones can be enormous. Unpaid care accounts for 74.8% of the total cost of people with dementia living in the community, and 45.7% of the total cost of the overall population of people with dementia in Wales. Our research found that people with dementia, carers and their families currently shoulder around two-thirds of the costs of dementia themselves. It is hoped these findings will concentrate the minds of all those who have responsibility for improving the lives of people with dementia, and that this focus will help to move Wales closer to the goal of becoming a truly dementia-friendly nation.



	Mild	Moderate	Severe	Average
Community	£3,129	£7,712	£10,571	£4,082
Residential Care	£24,129	£25,177	£25,084	£25,002
All settings	£5,297	£20,996	£21,460	£12,302

Figure 1 - Source: Alzheimer's Society (2015) *The Hidden Cost of Dementia in Wales*, Cardiff: Alzheimer's Society.

[25] IPPR (2009) *Expectations & Aspirations: Public attitudes towards social care*, London: IPPR.

Financial Pressures on the social care system

5.1 According to Social Care Wales, while 14,000 social care workers were recruited by care providers commissioned by Welsh local authorities in 2016, 11,000 staff also left commissioned care providers. This churn in the sector can result in a lack of consistency in service delivery, additional financial burden on providers to recruit and train new staff, and strain on other staff in covering vacant positions. Out of the 70% of leavers who's destinations were known, 32% left the sector and 5% retired.[26]

5.2 There are a range of issues which affect staffing difficulties in social care, including staff recruitment and retention, such as low pay, lack of security in terms of contracts, well-being and support, workers' rights, and the lack of a proper career pathway. All these issues need taking into consideration when Welsh Government sets policy, and public services should address them when developing workforce planning.

5.3 Alzheimer's Society is concerned about the impact of Brexit on adult social care particularly on the workforce. We are concerned that any restrictions on the free movement of people between the UK and the rest of the EU and EEA, will exacerbate the current shortfalls in staffing in adult social care and make the option of working in adult social care in the UK an even more unattractive and uncertain profession.

5.4 As the UK prepares to leave the European Union, it is vital that negotiations feature dementia research and care at the centre of discussions. We believe that the Government must consider the impact of Brexit negotiations on the adult social care workforce. We must ensure that the resulting deal between the UK and the Union guarantees that the UK remains a centre of excellence in dementia care and research and that people with dementia are not disadvantaged, either now in the future, by the change in our membership. Leaving the European Union could present multiple challenges in relation to dementia, and one of the principle issues is that in many areas the full impact on people is still unknown. Negotiations to leave the European Union started in June 2017 but have not yet reached firm agreements on the areas that could impact people with dementia.

5.5 This specifically incudes the impact of any changes to migration policy on the ability of EU and EEA nationals to work within the UK. Brexit could result in a shortage of nurses, given that 10,000 of the nurses arriving into the UK per year are from the European Economic Area. In the social care sector, research by Independent Age indicates that nearly 1 in 5 care workers was born outside the UK – around 266,000 people.[27] There are currently 144,000 people with EU nationality working in health and social care, approximately 80,000 of which are in adult social care. While specific data for Wales is often not available, the Welsh Government has claimed that as of September 2015 around 1,140 EU nationals were employed in NHS Wales, with 6% of doctors in Wales having trained in other parts of the EU.[28] The Government must act to ensure that adult social care is made an attractive career choice to address current shortfalls in recruitment and retention of staff.

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[26] The Local Government Data Unit – Wales (2017) *Social Care Workforce Development Partnership (SCWDP) workforce data collection 2016: the findings*, Cardiff: Local Government Data Unit – Wales.

[27] Independent Age (2015) *Moved to care: the impact of migration on the adult social care workforce*, London: Independent Age.

[28] Welsh Government and Plaid Cymru (2017) *Securing Wales' Future: Transition from the European Union to a new relationship with Europe*, Cardiff: Welsh Government.

Future social care needs and related costs

6.1 We know there is a projected increase in demand for social care by an increasingly large population of people with dementia. It is important that this demand is met by public, private and third sector organisations that are well equipped and properly funded to deliver high quality services. The picture in Wales is often thought to be better than England, as "social services spending has more or less been protected."[29] Despite this, we are strongly concerned about a shortfall in funding for social care provision in the future.

6.2 We are glad that Welsh Government has *"prioritised social care as a sector of strategic national importance"* according to the Minister for Children and Social Care, Huw Irranca-Davies AM.[30] The Welsh Government has also taken concrete steps to support the social sector and underpin this commitment with additional funding, as "*a total of £55 million of recurrent additional funding has been provided to local authorities for use in social services in 2017-18*" and "*£60 million for the delivery of integrated care across Wales"* through the integrated care fund which *"includes funding for reablement services, support for timely and effective discharges from hospital, and integrated care teams."*[31] We also welcome the recent funding (November 2017) of £1 million to improve support available to carers by enabling access to breaks from caring, supporting identification of carers, and providing information and assistance.[32]

6.3 This is welcome in order to support the existing system and services. However, we fear that it will not enable the social care sector to meet the challenges confronting Wales and Welsh public services in the future.

6.4 The Health Foundation have projected that cost pressures for adult social care in Wales will increase by 4.1% annually up to 2030-31 or by £1 billion, due to demography, chronic conditions (such as dementia), and rising costs. [33] [34] This would be a near doubling by 2030, and push spending up to £2.3 billion.[35]

6.5 Spending will need to keep pace with this – meaning that by 2022-23, Wales would need to spend an extra £184 million per year in 2015-16 prices above and beyond what was already spent by local authorities in that year.[36] Research done by Wales Public Services (WPS) 2025 demonstrated that pressures in social services budgets drive 2.9% growth each year, which is around £43m annually up to 2019-20.[37]

6.6 This would be to maintain existing standards. In order to maintain pre-austerity (2009-10) levels of per-capita, spending on older adult social care would require a

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[29] Ogle, J and Trickey, M (2017) *Can Wales fill the social care funding gap*?, IWA website, date accessed 18/01/2018.

[30] Irranca-Davies AM, Huw (2017) Questions to the Cabinet Secretary for Health and Social Services—Postponed from 8 November, Record of Proceedings, National Assembly for Wales, 15th November 2017, date accessed 26/01/2018.

[31] Irranca-Davies AM, Huw (2017) Questions to the Cabinet Secretary for Health and Social Services—Postponed from 8 November, Record of Proceedings, National Assembly for Wales, 15th November 2017, date accessed 26/01/2018.

[32] Welsh Government (2017) *Carers Rights Day: Welsh Government unveil new plans to improve the lives of carers*, date accessed 26/01/2018.

[33] Watt & Roberts (2016), *The path to sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31*, London: The Health Foundation.

[34] WPS 2025 (2017) *The future funding of health and older adult social care in Wales*, date accessed 18/01./2018.

[35] Ogle, J and Trickey, M (2017) *Can Wales fill the social care funding gap*?, IWA website, date accessed 18/01/2018.

[36] WPS 2025 (2017) *The future funding of health and older adult social care in Wales*, date accessed 18/01./2018.

[37] Jeffes, M (2013) *Future pressures on Welsh Public services*, cited in WLGA (2016) *Submission to National Assembly Finance Committee Welsh Government Draft Budget 2017-18 scrutiny*.

similar level of additional resource to the Health Foundation estimates above - around £168 million extra relative to 2015-16.[38]

6.7 We know local authorities are under pressure. WPS 2025 estimates local authority spending per older person has declined over the last seven years by around 13% and that £134 million a year more would be needed by 2020-21 to get back to 2009-10 per-capita levels.[39] A survey of councils in England and Wales found 75% had little or no confidence in the sustainability of local government finances. In addition, more than 40% of all councils anticipated making "cuts in frontline services". [40]

6.8 Local authorities are increasingly looking to third sector organisations to provide for shortfalls in their own service provision. But there are growing examples that independent organisations providing residential and home care are struggling to remain viable, caught between squeezing local authority funding for care contracts, challenges in recruiting and retaining staff, and increasing workforce costs (for the national living wage, pensions, and national insurance employer contracts). 13 of Wales' 22 local authorities told the BBC that they had had contracts handed back to them by providers unable to bid, a higher proportion than across the UK (59% in Wales compared to 48% average across the UK). [41]

6.9 This underfunding has negatively impacted the quality and volume of care that people with dementia receive. Inaction on social care reform has left thousands of people without the support they need. Too often we hear the consequences of inadequate care – our Fix Dementia Care investigation last year revealed people with dementia left in soiled sheets or being left for days without food.[42]

6.10 Informal and unpaid carers are bearing the brunt of this funding shortfall for adult care services. Often carers and people with dementia will pay care fees which are actually higher than the cost of delivering the care they receive for support that is frequently disjointed and variable in quality. Sometimes these costs total hundreds of thousands of pounds, with Alzheimer's Society's latest estimates projecting it would take 125 years to save for the typical cost of dementia care. Additionally, even where people do meet the strict means test threshold for council funded care, people with dementia face having to pay top up fees and other unexpected costs. This can be anything from hotel costs to costs for dementia being a 'complex' condition.

6.11 We believe that this system is unfair, unsustainable and needs a long-term overhaul, to ensure that people with dementia receive affordable and high quality care as and when they need it. We require a system that encourages people with dementia to access care early enough to live well and reduce the need for more costly and stressful acute care further down the line. We call for the establishment of a care system that recognises the true cost of dementia care and ends the unfairness that currently exists between dementia and most other conditions. We know that there are major challenges to ensure that the right health and social care services are available in Wales and are sustainably funded. But it is only through this will we be able to ensure that people with dementia are not treated unfairly because of the condition they have and are able to access the same level of care as those with other physical conditions.

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[38] WPS 2025 (2017) *The future funding of health and older adult social care in Wales*, date accessed 18/01./2018.

[39] Ogle, J and Trickey, M (2017) *Can Wales fill the social care funding gap?*, IWA website, date accessed 18/01/2018.

[40] Institute for Fiscal Studies (2017) *The local vantage: how views of local government finance very across councils*, IFS: London.

[41] BBC (2017) *Home care firms in Wales facing 'desperate' pressures*, date accessed 22/01/2018.

[42] Alzheimer's Society (2017) *Turning up the Volume: unheard voices of people with dementia*, London: Alzheimer's Society.

Financial Impact of current Welsh Government policies

7.1 The most noticeable financial impact of Welsh Government policies on people affected by dementia in Wales are charges for non-residential and residential care.

7.2 Non-residential care can be provided by local authorities or commissioned from private or third sector providers, such as Alzheimer's Society Cymru. Local authorities have discretion over whether to charge for these services, although all local authorities do charge. The scope of these charges are constrained by legislation, primarily the Social Services and Well-being (Wales) Act 2014 which provides for a maximum weekly charge for non-residential care services of £70 (2017-18).[43] People receiving services are entitled to retain a minimum income. A capital limit in the means test for non-residential care of £24,000 also applies. The capital limit determines whether a person pays for the full cost of their residential care, or whether they receive financial support towards the cost from their local authority.[44] Below the capital limit, individuals are not expected to contribute to the costs of their non-residential care from their capital.[45]

7.3 In the Fifth Assembly, the Welsh Government has announced that this capital limit will be raised to £50,000, on a progressive basis. In October 2016, the Minister for Social Services and Public Health at that time Rebecca Evans AM, announced[46] that the Welsh Government would raise the capital threshold to £30,000 and introduce the War Disablement Pension disregard from April 2017 as a first step in implementing the reforms to charging for residential care. The Social Care Minister, Huw Irranca-Davies AM, has recently announced that this capital limit will increase to £40,000 in April 2018.[47]

7.4 Alzheimer's Society Cymru welcomes this rise, but would advocate that in order to protect the majority of people, it should be set higher to ensure that those with fewer assets are protected by the State. A higher capital limit of "at least £100,000" was proposed by the Wales Stakeholder Advisory Group on Paying for Care in 2015.[48]

7.5 Welsh Government is also proposing reforms to the maximum weekly charge for no-residential care services by raising it from £70 in 2017-18 to £100 in 2021.[49]We welcome the maximum weekly cost placed on homecare but would advocate that in order to protect people with dementia adequately there should be a limit on what people pay overall. Many individuals with dementia may have a need for long term non-residential care and thus have a significant cost over a lifetime. We agree that "a lifetime cap on care costs should be introduced for residential care. The cap should also be timebased to provide assurance over the length of time a person might have to pay charges" as proposed by the Wales Stakeholder Advisory Group on Paying for Care in 2015.[50]

7.6 We are also concerned about the current impact of the system of carer's assessments on people affected by dementia. We are greatly concerned that the eligibility criteria for carer's assessments are too high to properly assist carers in need of support. At present,

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[43] Boyce, Stephen (2017) *Research briefing – Paying for adult social care in Wales: Debate and Reform*, Cardiff: National Assembly for Wales Research Service.

[44] Welsh Government (2017 *People in residential care to keep even more of their money*, date accessed 23/01/2018.

[45] Boyce, Stephen (2017) *Research briefing – Paying for adult social care in Wales: Debate and Reform*, Cardiff: National Assembly for Wales Research Service.

[46] Welsh Government (2016) *Written Statement – Implementation of Taking Wales Forward Commitments on Charging for Social Care*, date accessed 24/01/2018.

[47] Welsh Government (2017 *People in residential care to keep even more of their money*, date accessed 23/01/2018.

[48] Boyce, Stephen (2017) *Research briefing – Paying for adult social care in Wales: Debate and Reform*, Cardiff: National Assembly for Wales Research Service.

[49] Boyce, Stephen (2017) *Research briefing – Paying for adult social care in Wales: Debate and Reform*, Cardiff: National Assembly for Wales Research Service.

[50] Boyce, Stephen (2017) *Research briefing – Paying for adult social care in Wales: Debate and Reform*, Cardiff: National Assembly for Wales Research Service.

too many carers are only assessed as having 'eligible need' for support when they are already close to breakdown. The need to avoid carer breakdown is generally well-recognised to support the carer's own wellbeing and health, and the knock-on effect on those for whom they provide care. Carers assessments need to be focused on support to prevent breakdown, not on helping when a carer is already in crisis. We are concerned that high eligibility criteria means that more carers are being driven to the point of breakdown unnecessarily.

7.7 This must be avoided in order to better help carers and those they support, and to reduce financial cost. It is important to support the health and well-being of carers and those they care for, particularly because the care required at a crisis is far more expensive to deliver. We are concerned that high criteria may save money in the short-term by enabling public services to provide fewer services to carers on an ongoing basis, but risks necessitating more expensive crisis care, as well as forcing vulnerable individuals into worse health outcomes.

7.8 Alzheimer's Society Cymru wants to see firmer targets for carers' assessments. We welcome the Welsh Government's commitment to examine a national approach to respite care. We must ensure that carers' assessments reflect the realities of living with dementia – for example, that dementia is a progressive condition and the needs of a carer may vary over the course of a person's condition. As such, a carer's assessment should be the start of the conversation, not just the end.

Fiscal levers available to the Welsh Government to reform the arrangements for funding social care

8.1 It is clear we need reform of the social care funding system if we are to meet the challenges of the future. Reform is long overdue -– and given the controversy earlier in the year over plans for a "Dementia Tax" in England, it is time for Wales to lead the way by examining progressive models that could give us properly funded social care.

8.2 The General Election in 2017 showed us how salient the Dementia Tax was to many people. Though Wales has a devolved social care system and proposals from the election would not directly affect Wales, the Welsh Government is taking steps that could potentially address the underfunding of social care in Wales.

Social Care Levy

8.3 The Welsh Government has announced proposals to introduce a 'social care levy' to meet the longer-term challenges to finance social care. As we currently understand it from the Welsh Tax Policy Report[51] the Welsh Government expects to propose a new tax to the UK Government in 2018, as per the powers to raise new taxes that Welsh Government has under the Wales Act 2014. The social care levy is one of four currently discussed potential taxes. [52]

8.4 The Welsh Government has set out its tax policy principles in the paper for the development of new taxes. To test the mechanism, the Welsh Government expects to provide information to the UK Government on whether a new tax is within the competence of the National Assembly for Wales; whether a policy case exists for such a tax and whether it has harmful effects for UK macro-economic or fiscal policy. The Welsh Government has looked at the extent to which proposals address the priority areas in the Prosperity for All national strategy, analysed how they might meet our framework criteria, and conducted initial engagement with the relevant departments to select the new taxes with the most potential.

8.5 Welsh Government will explore "potential financial levers including taxation to support social care provision in Wales."

8.6 Alzheimer's Society Cymru will do all we can to work with the Welsh Government as they explore the practicalities of a social care levy. However, there are many ways such levers could be utilised and many ways to develop a levy for social care. We believe that any proposals – such as a hypothecated tax or social care levy; a cap on care; or insurance-based models such as are used in Germany and Japan – should meet a stringent set of criteria in order to meet the needs of people affected by dementia.

Principles for reform

8.7 We believe that any new fiscal levers or policy decisions on social care funding designed to better support people affected by dementia should:

- **Address the considerable inequity of support between dementia and other conditions.**
  People with dementia should not receive less support, increased charges and costs nor face challenges accessing care based on their age or the increased need for social care as a result of having dementia.
- **End catastrophic care costs for families.**
  While some people with dementia may make some contribution towards the cost of their care, this is a fair amount which has a financial limit and does not

[51] Welsh Government (2017) *Welsh Tax Policy Report*, Cardiff: Welsh Government.
[52] The other ideas being a "tourism tax", a tax on non-recyclable cups, and a tax on vacant land.

impact on their wellbeing or ability to live a normal life. No individual should have to spend everything they have on care. In order to end catastrophic costs, any reforms to social care must have adequate funding in the long-term and we believe that in order to do so, the Government must commit to creating a new annual influx of funding for social care.

- **Ensure a better connection between the price paid for dementia care and the cost of providing this care.**
  The cost of delivering high quality care provided by professionals who are both confident and competent must have a close and transparent connection to the price that people pay for their care, regardless of how that care is commissioned. As it stands in the current system, people with dementia are faced with paying top-ups for their care, the significant price of cross-subsidising and the system not taking into account the additional cost of dementia care. In addition, people are having to spend additional funds on hotel costs and are shouldering larger financial burdens as a result of years of underfunding of the system. It is vital that the Government prioritises immediate action in this area to ensure that there is a better connection between the price paid for care and the cost of providing this, to ensure that what people are paying is more fair and reflective.

- **Guarantee greater efficiency across health and care, providing preventative support in the appropriate setting.**
  In addition to an adequately funded care system, it is absolutely vital that we ensure the health and social care systems are utilising the funding available in the most efficient way to minimise wastage on the one hand and direct the funding in ways that will ensure the wellbeing of people with dementia. For instance, great importance is currently being placed on reducing delayed transfers of care (DTOCs) by placing additional funding into healthcare. However, as an organisation we believe that a holistic and whole-system approach is needed to address these challenges. Therefore, we are calling for the Government to take a comprehensive view over where the funding is currently being spent, where the wastage currently occurs and how this can be spent differently to the benefit of people with dementia. Alzheimer's Society intends to put forward evidence that demonstrates the money wasted on avoidable admissions, DTOC and emergency readmissions for people with dementia. This will focus on and underline both the costs borne by the health system due to the failings of social care but also the terrible damage this can do to people with dementia and their families who have not been provided with the support they needed within the community. In order to fully understand this, the Government must place importance on ensuring evidence and data regarding the system as a whole is strengthened (specifically in relation to dementia).

- **Ensure better quality of care for people with dementia across health and social care.**
  We know that there is poor care, insufficient training, and waste throughout the health and social care system – combined with concerning variation across Wales and lack of clear standards, this is a challenge that needs to be addressed. We are hopeful that the forthcoming Welsh Government dementia action plan will address these disparities in the quality of care. Our full response to the consultation on the draft dementia strategy can be found at: www.alzheimers.org.uk/walesstrategy17

8.8 These principles should guide reforms to social care funding. Any proposed reforms should be in the service of good quality care for vulnerable people with dementia, which must always be the core and most important goal. Good quality care should be

based on individual need, and focus on ensuring that there is appropriate training and understanding from care workers of the challenges that people affected by dementia face. We want to see homecare that provides continuity of familiar faces where possible, proper recording of care plans, minimal use of 15 minute visits, and care homes that are dementia friendly environments, have ways to keep people connected to the community and have appropriate staffing levels.

8.9 This should also feed into service commissioning. It is essential that commissioners understand the complex nature of dementia and provide services that meet those needs. The requirement in the Well-being of Future Generations (Wales) Act 2015 for Public Service Boards to produce Assessments of Local Well-being[53] will hopefully help commissioners better understand local prevalence of dementia and future projections, and commission services appropriately. We know that this is a challenging time for commissioners, with "a steady reduction in the number of both residential and nursing homes across Wales"[54]and commissioners saying they "need more extra care, EMI residential and nursing care and less residential care"[55]. Commissioners need to ensure that appropriate fees are paid to providers to deliver quality care for people with dementia, including appropriate training and appropriate pay & conditions for staff.

8.10 We know that care work has a "particularly low social status, reflected by low pay, long working hours, poor working conditions and a lack of opportunities for professional development and career progression".[56] This work is often "emotionally, mentally and physically challenging and demanding"[57] and current rates of pay are seen as "undervaluing the contribution made" by staff.[58] This can lead to low morale, high stuff turnover, and a lack of consistent care – which has a detrimental impact on the quality of life and care of staff and people with dementia.[59] [60] It is a false economy for providers/operators to limit pay as staff should be incentivised and rewarded for maintaining high quality care and to avoid staff turnover.[61]

8.11 Additionally, it is important not only that people affected by dementia and their needs are at the centre of their care, but that they have a voice themselves in decisions regarding their care. People should have control over the outcomes that help them reach well-being. This is a key principle of the Social Services and Well-Being (Wales) Act 2014 and must be upheld to a greater degree by commissioners.[62]

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[53] Available at: http://gov.wales/topics/improvingservices/public-services-boards/?lang=en
[54] Rattle, N. and Moultrie, K. (2015) *The Care Home Market in Wales: Mapping the Sector,* Cardiff: PPIW.
[55] Interview with local authority commissioner, low population density area, cited in Rattle, N. and Moultrie, K. (2015) *The Care Home Market in Wales: Mapping the Sector,* Cardiff: PPIW.
[56] Older People's Commissioner for Wales (2014) *A Place to Call Home? A Review into the Quality of Life and Care of Older People living in Care Homes in Wales*, Cardiff: OPCW.
[57] Older People's Commissioner for Wales (2014) *A Place to Call Home? A Review into the Quality of Life and Care of Older People living in Care Homes in Wales*, Cardiff: OPCW.
[58] Tadd W, Woods R, O'Neill M, et al (2011). *Promoting Excellence in all Care Homes (PEACH)*. PANICOA.
[59] Older People's Commissioner for Wales (2014) *A Place to Call Home? Literature Review*, Cardiff: OPCW.
[60] Colliers International (2013). *Care Homes Review*, London: Colliers International.
[61] Colliers International (2013). *Care Homes Review*, London: Colliers International.
[62] Social Care Wales (2017) *Overview: Social Services and Well-being (Wales) Act 2014*, date accessed 26/01/2018.

Our position on social care funding reform

8.12 Alzheimer's Society Cymru believes that any proposed reforms to social care funding need to address the needs of people affected by dementia. Given the demographic changes discussed earlier, it is clear that a greater proportion of those who are affected by social care funding will be people affected by dementia in the future.

Medium-term solutions

8.13 Alzheimer's Society supports the creation of a cap on care costs that works for people affected by dementia, which would prevent people from spending all they have on care. Establishing a cap on the care costs is essential to ending the catastrophic cost of care people with dementia face now, and is the first step to ending over all inequity people with dementia face as a result of the current health and care system compared to those with other conditions. Alzheimer's Society research showed that people with dementia are, on typically, spending £100,000 on their care over the course of their lifetime, highlighting the devastating cost they and their families face[63].

8.14 This must happen in conjunction with a rise in the means-test threshold to would protect people with modest means from having to pay for their care. Alzheimer's believes that in order to adequately protect the population, both elements should be implemented together. The implementation of a limit on overall care costs and increase in the means-test threshold would be a crucial first step towards ending the inequality that currently exists between dementia and other conditions. This would constitute a medium-term reform to the care system, as it would place a maximum cost on dementia care and therefore would put an end to spiralling costs for the first time.

8.15 Alzheimer's Society has commissioned LaingBuisson to determine and consider what level a cap should be set at in order to protect the majority of people affected by dementia from uncontrolled cost, using figures from England. As a starting point, this research[64]used the original £72,000 cap that was set out in the Care Act 2014 (the implementation of which has since been postponed) to project the number and proportion of service users with dementia who might benefit this cap. The latter demonstrates that if the cap was set at £72,000, 17% of eligible residents across England would have reached this in their lifetime. At a cap value of £120,000 the proportion would drop to 2% and at a cap value of £50,000 it would rise substantially to 38%, which highlights how redundant a cap becomes to people with dementia if it is set too high. Viewed from another angle, 20% penetration would require a cap of £68,000, 25% would require £63,000 and for a majority (51%) to benefit from the care cap would require it to be set at £41,000.

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[63] Alzheimer's Society (2017) *Turning up the Volume: unheard voices of people with dementia*, London: Alzheimer's Society.

[64] Alzheimer's Society (2017) *Laing Buisson proposes solution for funding social care – Alzheimer's Society comments*, date accessed 15/01/2018.

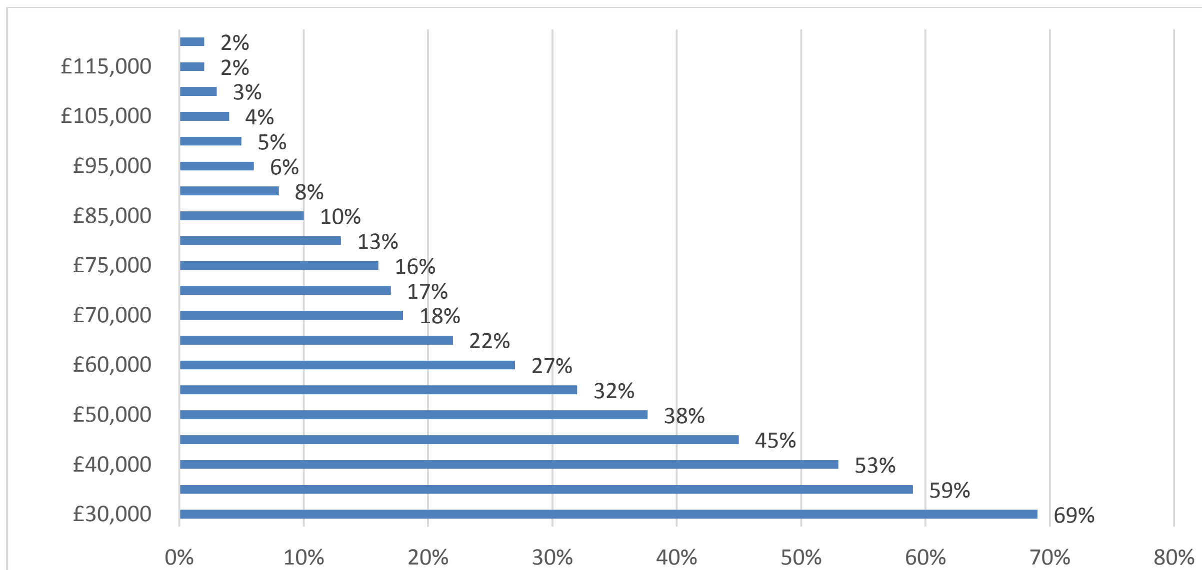

Figure 2: Share of eligible, older (65+) care service users with or without dementia who will have reached a lifetime care cost cap set at different levels at 'steady state' (in up to 10 years), England

8.16 If the means-test threshold was raised to £100,000, it would transfer a projected 27,900 older care home residents with dementia in England out of private pay and into council financial support. This would raise the proportion of people with dementia who have access to public funding, through councils or the NHS, from 54% to 66% across England. Significantly, however, this higher means test would not include the home as an asset for residential care, and would provide far less protection if this was the case.

8.17 Obviously with different current fees for care and a different means-testing regime with capital limits in Wales, appropriate figures will be different. However, this information may provide a useful starting point for future research to be commissioned.

8.18 Alzheimer's Society Cymru acknowledges that this in itself would not put an immediate end to the current inequity between conditions, as people with dementia would still face a significant financial responsibility for paying for their own care. It would, however, guarantee that many more people no longer have to spend everything they have and would ensure greater public understanding of the care system and the risks that people could face if they develop a care need.

Longer-term solutions

8.19 In the longer term, fiscal levers could be used to develop more radical solutions. In order to end catastrophic costs, any reforms to social care must have adequate funding in the long-term and we believe that in order to do so, the Government must commit to creating a new annual influx of funding for social care. In the longer-term, Alzheimer's Society supports the creation of a system that wholly pools the risk of dementia across society and ensures that people with dementia no longer have to face a disproportionate financial responsibility just because of the condition they have developed. No solution around a cap or increased asset floor will work unless this is the long-term goal.

8.20 We agree with the proposal of the Wales Stakeholder Advisory Group on Paying for Care that "[i]n the longer term, care and support should be paid for

through national insurance, or taxation, to pool risk."[65] The Group also said there may be a role for tailored and reliable financial products, such as annuities to fund care.

8.21 To this end, a social care levy may be the appropriate method. However, we would need to better understand the details of the Welsh Government's proposals to estimate the impact, positive or negative, that this reform could have on people affected by dementia in Wales. If this option is taken forward by Welsh Government, we would recommend the Welsh Treasury engages with people affected by dementia directly in order to understand their needs and experience of social care funding.

8.22 We believe that pooling risk is essential, and as such any distinct funding stream for social care should be Wales-wide. This will pool risk between areas which may have different levels of prevalence of dementia and different tax bases. For example, an area with a larger number of older people who have a small number of assets would need to spend larger amounts on dementia care, which exposes that local authority to far greater risk. While the Council Tax precept in England is welcome as a new source of funding for social care provision, it does not address the mismatch between the amount needed to fund acceptable care in an area and the amount the Local Authority has to spend on care in that area. It is likely that the business rates changes will encounter the same issue. There is no accepted cost for delivering care in an area. Whilst it is possible to see what Local Authorities pay for care, and what providers charge for care there remains no way for locally elected representatives, or the voters in an area, to see whether the amount that is being paid for care in that area is reasonable compared to the local cost factors and needs of the population. We suggest that in the long term the settlement which is provided to Local Authorities to pay for adult social care is more explicitly linked to the cost of providing an acceptable level of care in that area.

8.23 In addition to placing a maximum on the financial responsibility that people with dementia face and thereby re-balancing the responsibility between the individual and the state, Alzheimer's Society also supports a cap as a way to stimulate an insurance market that will enable people to protect themselves against the risk associated with the cost of dementia. One way to do this would be to implement a compulsory social insurance system, similar to systems already implemented internationally such as Germany and Japan. Alzheimer's Society would support this as it builds upon the cap on care/means-test threshold system in ending catastrophic costs and enabling the provision of high quality and affordable care in the future. It also ensures there is fairness between generations.

8.24 Private long-term care insurance allows people to take out individual products to help cover the cost of care. Specifically, in its current form it is intended to cover the cost of assistance for those who need help in performing the basic activities of daily life, such as getting out of bed, dressing, washing and going to the toilet.

8.25 There are two predominant types of long-term care plans; immediate needs annuities and pre-funded care plans. In the former, someone would pay a guaranteed income for life to help cover care fees in exchange for a one-off lump sum payment, if someone has immediate needs . The average price of an immediate care need annuity plan is £69,000.[66] While this may therefore not cover the entirety of someone's dementia care, which currently stands at a typical cost of £100,000 across someone's care journey, this would cover the majority of average dementia care costs. If a person chooses a pre-funded care plan, they will be able to insure against their future care needs before such a care need develops. Payment is usually in the form of a monthly payment and someone becomes eligible for the benefits

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[65] Boyce, Stephen (2017) *Research briefing – Paying for adult social care in Wales: Debate and Reform*, Cardiff: National Assembly for Wales Research Service.

[66] Forder, Julien (2011) *Immediate Needs Annuities in England*, Canterbury: PSSRU.

after being classed as being ‘chronically ill’ (or similar). Although the definition of what this entails varies according to the country and company, someone will usually be assessed by a licensed health care professional and eligibility usually entails someone being unable to perform at least two Activities of Daily Living. These could include:

- Eating (whether someone can feed themselves)
- Bathing (whether someone is able to bathe themselves)
- Toilet (whether someone can use the bathroom by themselves)
- Dressing (whether someone can get dressed by themselves)
- Continence (whether someone is able to control their bladder and bowel function)
- Mobility (whether someone is able to get into or out of a bed, a chair or a wheelchair)

8.26 Although these products could in theory benefit people affected by dementia, they are not being used due to multiple and intertwining factors:

- In order for a market to be stimulated, there must be clarity about the system and what someone would end up paying for care if they needed it. There is a lack of awareness and understanding about the long-term insurance industry and how this works.
- There is an overriding lack of understanding relating to how the system currently operates and what people are entitled to. A major barrier is that people assume all care is free through at the point of use through the NHS and therefore are unaware of the risks associated with older age and specific condition, such as dementia.
- To make matters worse, the care system is currently very complex and lacks transparency, which further disempowers people from protecting themselves against the risks associated with conditions and their end of life care.
- People do not currently see the value in purchasing insurance for something that will statistically not happen to them – the stakes are too high.
- The premiums for such products are currently too high to be attractive to people.

8.27 While we believe private insurance is in principle beneficial to people affected by dementia, insurance must be set up in a way that supports and empowers people with dementia rather than taking advantage of people with dementia or disadvantaging people, such as:

- Ensuring that people with dementia are not disadvantaged because they already have a diagnosis, or a genetic predisposition for the condition, which is now available through DNA tests such as 23andme.
- Ensuring that the process and information is accessible to enable people with dementia to easily navigate the insurance product when they choose to take this out

8.28 The following countries have made significant strides in creating compulsory insurance models for care, which we as a country could draw upon when reforming our own care system:

8.29 **Germany:** The German social long-term care insurance is a compulsory pay as you go system with contribution based on salary, split between employee and employer. Initially, the contribution rate was 1% in 1995 and for the next financial

year (2017-2018) will be 2.55%. In addition, employees over 23 who do not have children pay an extra 0.25% of their salary (as they have an absence of support from their offspring and are more likely to need paid for support). 90% of the German population is covered by the scheme, including retired people and recipients of social welfare and unemployment benefit.

8.30 German long-term care insurance is not intended to cover all costs, but just basic needs. Recipients of long-term care are expected to make a contribution themselves or apply for means-tested welfare benefits. Anyone with a physical or mental illness or disability, who has made contributions for at least two years, can apply for benefits. Assessment is carried out by doctors and nurses mandated by medical review boards, with costs charged to the long-term care insurance fund.

8.31 **Japan:** Japan's compulsory public long-term care insurance covers the needs of the population aged 40 and over. Benefits are designed to cover the costs of care, minus a 10% co-payment. The intention is that social care services provide a substitute for informal care. The LTCI is primarily designed to cover the care needs of those aged 65 and over; for adults aged 40-64 the system only covers long-term care needs arising from age-related disease (such as dementia). Benefits cannot be taken as cash - they must be taken as formal services. Approximately 50% of revenue for the long-term care insurance scheme comes from general tax, 1/3 from premiums from people aged between 40-64 (in addition to 1/6th from people over 65). User co-payments account for the rest.

8.32 **The Netherlands**: The Netherlands has a universal social insurance scheme, AWBZ, which pays for the care of older and disabled people. This covers both home care and care provided in residential facilities, including accommodation costs. The extent of care provided is determined by a needs assessment and a complex set of cost-sharing arrangements apply. Patients have the option to receive services in kind or to receive a personal budget to pay for personal care, home care and support with daily activities. The budgets are calculated based on the number of hours of care needed and patients must top up their budget with income-related contributions to buy the level of care they are assessed to need (in reality most recipients use the money provided by the scheme and buy less care than their assessed need). The budget can be used to pay relatives for providing informal care. The compulsory social care social insurance scheme is administered by private insurance companies and paid for via an income-related premium deducted from the wages of all citizens aged 16 and over, and an employer contribution. Individuals who use services also have cost-sharing obligations that vary depending on their level of income, their family status and the location of care.

8.33 **Costa Rica**: Costa Rica, which is ranked in 69th position in terms of GDP per capita, is also ranked at a very high 35 on the Human Development Index. Due to its strong welfare state and provision of a compulsory social insurance (Caja Costarricense del Seguro Social). Costa Rica has the highest life expectancy for males and the second highest for females (of Latin American countries). According to the WHO, the success of the health system was in part due to a higher social public expenditure. Arguably, it was also a result of integration – as the health services and public institutions responsible for social care provision have been brought together.

8.34 The WHO has stated that the "relatively rapid growth of the elderly population as a result of improvements in their quality of life, are compelling policy-makers to consider a potential increase in the demand for long-term care over the next 25 years. Some efforts to provide increased LTC at the institutional level have been implemented, in particular through the reform of the health system and the law concerning integral care of the elderly."

8.35 **Lithuania**: The country is administratively divided into ten districts, each of which is led by a centrally appointed district governor. These districts have certain responsibilities In the realms of health and social care. There have been significant changes to the way in which the system is operated, which has been prompted by two major events, including the establishment of a state health insurance system and new legislation, which redefined the status of health care institutions.

8.36 In Lithuania, the increase in life expectancy and the change towards an older demographic has contributed to a greater social care needs. So far, social care has predominantly taken the form of informal care but due to the change in the workforce this was no longer deemed feasible. Therefore, the country has laid the foundations for a social insurance system (through the Law on State Social Insurance), which has expanded over the last 20 years. In 1996, national state insurance became obligatory, which resulted in the creation of the State Social Insurance Agency that provides pension benefits, maternity and sick leave as well as being responsible for the collection of social insurance contributions. The social care system is funded through a levy of a certain percentage of personal income tax and payroll tax

8.37 Due to the fact that there is currently little active treatment and no cure for dementia, people with dementia rely predominantly on social care, as opposed to the NHS, which is free at the point of use. As such, they resultantly shoulder significant responsibility for paying for their own care due to the type of condition they have developed. As such, they could stand to benefit considerably through the establishment of a system that provides more protection against escalating costs and amounts to an important step in providing more equality between health conditions.

To consider the findings and conclusions of the Parliamentary Review.

9.1 Alzheimer's Society Cymru welcomes the publication of the Parliamentary Review into the Long Term Future of Health and Social Care in Wales. We welcome the statement by the Cabinet Secretary for Health and Social Services Vaughan Gething AM, that a long-term plan for health and social care will take into account these recommendations and be published in the spring.[67]

9.2 We agree that there should be one seamless system for Wales which organises care around the individual "as close to home as possible" and which is "preventative with easy access and of high quality, in part enabled via digital technology, delivering what users and the wider public say really matters to them." However, goals of more care in the community, more digital technology access, and more preventative approaches, should not come at the expense of *high quality care* when and where it is necessary.

9.3 The primary focus should be to securing the right care for people affected by dementia based on their individual needs. For many people, this will be at home and within the community, for as long as possible. However, we are concerned that the recommendation regarding "new forms of prevention and home- rather than hospital-based care" (p.44) and "developing Primary Care services out of hospitals" (p.47) could be used for closures of wards that fulfil vital services. It is important to remember that for conditions such as dementia, which are progressive and terminal, hospital specialist care is ultimately necessary for many individuals and community care is not a sufficient alternative. It is critical that adequate resourcing and training of staff is made available to appropriately deliver high quality, specialised care at all stages of dementia - wherever it is located; in the community, in residential care or at hospital. Alzheimer's Society Cymru have long called for more integration between health and social care and hopes that this develops in the future, combined with the right resourcing and sustainable funding to meet the changing needs of people living with dementia and supports the needs of carers.

9.4 We welcome the recognition that "the public, voluntary and independent sectors all have a role to meet the needs of the population now and in the future." We must ensure that third sector partners are seen as equals within the care pathway, and value the role that specialist services bring. There needs to be greater integrated working across health, local authorities, and the independent and third sector. Social Services often act as gatekeeper to people accessing third sector services through referrals. There should be greater cooperation between social services and third sector, in order to be able to provide a fuller range of appropriate support. Increasingly, dementia-specific service contracts are being given to general care providers, which fails to recognise some of the complex and specific needs of people with dementia that require specialist knowledge and training.

9.5 In particular, we believe that engagement with the voluntary sector is essential to deliver the Cabinet Secretary's vision of a dementia friendly nation. The Dementia Friends and Dementia Friendly Communities are key to ensuring that Wales is a place that is welcoming and accessible to all people affected by dementia.

9.6 It is essential that we "put the people in control" and "strengthen individual and community involvement, through voice and control in health and care, and ensuring all ages and communities have equal involvement". We believe that the new plan from the Cabinet Secretary should ensure that the voices of people affected by dementia are heard through direct user involvement activity. These voices should be at the heart of any proposed service change consultation processes for it to truly reflect the needs of people affected by dementia.

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[67] Welsh Government (2018) *"Different system of care needed to deliver for the people of Wales" says expert panel*, date accessed 25/01/2018.

Conclusion

We welcome the Finance Committee's interest in the important topic of social care funding. The dementia tax has affected people in Wales for far too long – and it is time to tackle this head on. We believe that we have a historic opportunity for reform, with the new dementia action plan soon to be published, proposals for a social care levy in Wales being discussed, and a forthcoming new green paper on care and support for older people in England.[68]

All of these areas of work need to include engagement with organisations in the third sector, the general public, and most importantly, with the people affected by any proposed changes themselves. We would be happy to facilitate consultation with people affected by dementia with Finance Committee in order to help Members better understand what people affected by dementia would want to see in any potential reforms. We know that the social care crisis is a dementia crisis and people affected by dementia should be at the heart of efforts to reform the system.

If you require any other information, please do not hesitate to contact me.

Yours sincerely,

Sue Phelps
Country Director, Alzheimer's Society Cymru

[68] UK Government (2017) *Government to set out proposals to reform care and support*, date accessed 29/01/2018.

SUBMISSION AS AN INDIVIDUAL FOR THE CONSULTATION

"THE COST OF CARING FOR AN AGING POPULATION"

ON BEHALF OF MRS [redacted] BY HER DAUGHTER MRS [redacted]

CONTACT DETAILS

[redacted]

Tel - [redacted]

Home – [redacted]

Address – [redacted]

CONSULTATION

THE COST OF CARING FOR AN AGEING POPULATION

I wish to refer to one point imparticular – to consider future social care needs and related costs. I understand this is just part of the picture but it is very relevant to my mums' case.

I have recently contacted the Older Peoples Commissioner for Wales Office to enquire about who should meet the cost of care home fees for people who do not currently qualify for continuing healthcare and even after paying for their own care for many years still have to pay for their own care because of their level of savings. Her office gave me the link to your consultation and informed me that apart from bringing my mums' case to the attention of the Commissioner there was nothing more they could do at present. (see copy of email attached)

I have also contacted Jayne Bryants' office who were able to give me the standard information that I am currently aware of regarding the present policies. I am now waiting for a meeting to be arranged with Jayne Bryant or an appropriate member of staff to discuss the subject further. (a copy of a letter from Carwyn Jones in 2016 sent to me is also attached)

On behalf of my mum, Mrs [redacted] nd from myself I would like to bring her case to your attention when discussing the subject of Fairness and who should cover the cost of care in an aging population?

My mum is 94 years old and has been in care since 2009. We have never managed wholly to find out why mum changed like she did, but one day she just could not take care of herself anymore, it literally happened overnight. After numerous doctors, hospital and specialist appointments we were none the wiser. So as a consequence after entering Residential care in 2009 she never returned to her own home or original quality of life. From **October 2009 to August 2015** she was in Emmaus Residential Home, Newport and paid the total sum of **£128976.00.** In August 2015 Emmaus Residential home closed, we were given 2 months to find mum a new place to live. As mum was bordering on nursing care we managed to have her assessed by a new home. Eleanor Hodson House Residential and Nursing home confirmed her need for nursing care. The total paid to the nursing home up to and including **February 2018 is £73449.61.** Bringing the total cost for mums' care to date to **£202425.61.**

I think you will agree that by anyones standards that amount is a substantial one. The care in both homes thankfully have been to a high degree and as a loving daughter who keeps a constant eye on the care she receives, I would not expect of accept anything else.

There was quite a lot of talk a few years ago about putting a cap on the total fees one person would be expected to pay for their care but was unfortunately lost in the system and it seems from various enquiries that there is no possibility of this re-emerging.

My mum is not in particularly in good health but is not at the stage of qualifying for continuing health care, thank goodness. Her finances are such that she will still have to pay for quite some time to come as we sold her bungalow after she had been in care for a few years, trying to invest the money to help pay for her care. We are now into that money as well.

Not all the residents in mums' nursing home are self funders for different reasons. It has recently been brought to my attention that the local authority are paying less for a placement than people that are self funding. As a result of hearing this , under the freedom of information act, I have asked Newport City Council for conformation of standard residential and nursing home fees paid by them for care during the period 2009 to 2018. When I receive this information I will be better qualified to comment and I can forward the information to you if you require it. If this is the case I think it disgraceful.

During this consultation could you please spare a thought for people who have been in care for many years who are self funding. We are not saying that care should be free to all, but surely after a few years maybe reduce the fees to half, with the local authority paying the other half. Then after a few more years for the local authority to take over.

The system as Carwyn Jones stated was unfair when he wrote his letter and is still quite obviously unfair now.

Yours hoping for a change in policy

Outlook Email

Search Mail and People

New | Delete Archive Junk | Sweep Undo

Folders

Inbox 2
Junk Email 2
Drafts
Sent Items
Deleted Items 150
Archive
Conversation History

Enquiry to Older People's Commissioner for Wales

JB
Wed 24/01, 14:14
You

Reply |

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Dear

Thank you for contacting the Older People's Commissioner for Wales and sharing the story of your mothers experience. I am pleased to hear that your mother has had such a positive experience of good quality care whilst living in her Care Home but understand the frustration you feel that your mother has so far paid £200,000 for her Care Home Fees and continues to Self-Fund.

I understand from our phone conversation earlier today that you have a thorough knowledge of the issues around self-funding and that your viewpoint is that there should be a cap on the amount of money a Self -Funder pays towards their Care Home Fee. You feel it is wrong that your mother has paid £200,000 and could potentially pay another £150,000 towards the cost of her care.

I am aware that you have been proactive in raise this issue with your Assembly Member, Welsh Government and The Older People's Commissioner for Wales. As well as highlighting this issue, I know that the question you are asking the Commissioner is simply, where you can go next for help?

The Commissioner encourages older people to actively engage in consultations about issues that affect their lives, so I have attached a link to the Welsh Government Finance Committee Consultation "The Cost of Caring for an Aging Population" which is running now up until the 31st January 2018 as you may wish to respond to this consultation as an individual.

http://www.senedd.assembly.wales /mgConsultationDisplay.aspx?ID=277

The Commissioner will be responding to this consultation and as part of this process we sometimes refer to anonymised Case studies that come to the attention of the Commissioner. It may be that the information you have shared with us will be used in this way but even if this is not the case, your mothers experience has been shared directly with the Commissioner who finds these shared stories invaluable sources of information.

I hope that you find this information useful and please feel free to contact the Commissioner again if you need advice or assistance in the future.

Yours Sincerely,

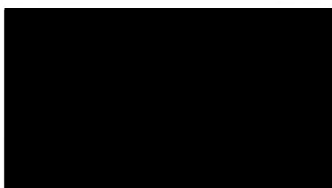
Senior Caseworker/Uwch Swyddog Achos

Older People's Commissioner for Wales / Comisiynydd Pobl Hŷn Cymru
Cambrian Buildings/ Adeiladau Cambrian
Mount Stuart Square/ Sgwâr Mount Stuart

Upgrade to Premium

Y Gwir Anrh/Rt Hon Carwyn Jones AC/AM
Prif Weinidog Cymru/First Minister of Wales

Ein cyf/Our ref: FM -/00094/16



24 February 2016

Dear Mrs

I am writing in response to your recent letter to me about the amount your mother has paid overall for her residential care.

I was sorry to read your mother now requires nursing care but pleased to see that her health has improved recently due to the excellent standard of care she receives. This must be reassuring for you and your family.

The current law governing charging for residential care (the National Assistance Act 1948) has been in place for over 60 years. As such, a person's capital assets in the form of property, savings and investments are taken into account in order to assess their ability to pay the cost of their care. Where a person has over the current level of the capital limit (£24,000), they are required to meet their residential care costs in full. From your letter, this appears to be applicable in the case of your mother.

However, it is clear that the current law has, over the years, become outdated and unfair, resulting in inconsistencies in the way people are charged for their social care. To remedy this, a programme of reform has commenced, starting with the charging arrangements for those who receive care and support in their own home or in the community. Since 2011, people in this position cannot be charged more than a maximum weekly amount for this, currently £60 per week. This applies to every person assessed as in need of such care and support, regardless of the level of their income or capital. This financial protection is unique to Wales.

As a next stage we have been considering reform of the arrangements which apply to charging for residential care, so as to make this charging fairer and more consistent. As I announced recently, if my Party, Welsh Labour, is re-elected as the Government of Wales in May's election we would double the capital limit so as to protect from charging more of a person's wealth. This means that people like your mother would be able to keep £50,000 of the value of her home, rather than the current £24,000.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

English Enquiry Line
Llinell Ymholiadau Cymraeg
YP.PrifWeinidog@cymru.gsi.gov.uk • ps.firstminister@wales.gsi.gov.uk

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

In the meantime, new legislation under our Social Services and Well-being (Wales) Act 2014 will be implemented from 6 April this year. Under this, a new charging and financial assessment framework will be introduced that will ensure greater consistency in charging for all forms of care and support. Although the capital limit will remain in place for the time being at its current level of £24,000, provisions under this framework will enable further reform to be introduced during the term of the next Welsh Government.

Yours sincerely

CARWYN JONES

Florence Justice Christian Residential Home

19 Stow Park Circle, Newport, NP20 4HF
Telephone & Fax 01633 221800
Email: florencejusticecarehome@yahoo.co.uk

Registered Provider: Mr M C Phelps

Finance Committee
National Assembly for Wales
Pierhead Street
Cardiff
CF99 1NA

30 January 2018

Dear Sir,

My name is Martin Phelps and I am a proprietor of a care home which provides residential care for up to 27 residents. The home does not provide EMI or nursing care. The following I submit as evidence for the inquiry concerning the cost of caring for an ageing population. In particular my evidence will inform the financial pressures on the social care system section of the inquiry.

Over the last ten years the costs of providing care have risen dramatically. Some situations likely to be faced by care providers are not considered by the councils that set the care rates; including the legal costs associated with employment. Individuals have greater ease of funding to take perceived staffing issues or disputes to tribunal or to court. It is clear therefore that care homes will sometimes be required to provide funding in order to defend themselves from such threats. I begin highlighting these risks, such as when care staffs have caused trouble for the home. Although not expected, it is often the case a home will lose reputation due to negative rumours spread by dissatisfied or embittered staff. The threat of loss of business due to those staffs will require funds to be available in order to be confident of facing threats from these staffs when their employment is terminated. Care homes may at the time

require funds for agency cover especially if staffs have left without notice. The funds to manage a care home through a situation which may require a high level of the more expensive ‘agency staffs’ do not appear to be considered by councils. This example, I hope, highlights the pressures care homes can sometimes face. We also feel the effect of when the local authority has “overspent” their budget and have reduced the number of admissions into care homes until the new budget becomes effective. This also increases “bed blocking” at the local hospitals. Perhaps there could be ideas on how to manage this.

On a more day to day level, I have found increased pressure due to the rise in wages and in pension. This is in addition to a continual annual increase from the council of at least 1% below the rise of index, thus creating a burning the candle from all ends effect. The result of this has been the need to reduce the quality of bought in goods in order to fund these other dictates. We have for example recently purchased supermarket “own brand” so that we can save forty pence per loaf of bread.

Aside from the changes to the quality of life of residents due to continual fiscal pinch, I feel I should also argue the case of wages of staffs having to be below what some staffs deserve as a wage and the fact the years have eroded the benefits of tokenism.

I hold concerns regarding the local council authority contracts. I would draw your attention in particular to plans to enforce a reduction in the rates for older people who are admitted from a care home into hospital. In the case of a large number of older people from our home requiring hospitalisation, the pressures of meeting the wage bill for our contracted staff hours would be serious. Would these pressures give rise to home owners feeling “what’s the point of carrying on?” There have been many homes closed and at some stage we will feel disheartened and question the financial viability when local authorities seem impervious to our plight. Similarly, a large number of deaths at the home can also raise such concerns. Given policies concerning older people in Wales, it is difficult to organise any type of drive to bolster numbers at times of sudden reduction in occupancy levels.

To discuss this further, please contact me on [redacted]

Yours Sincerely,

Martin Phelps

Registered Provider

FINANCE COMMITTEE: THE COST OF CARING FOR AN AGEING POPULATION

About us

1. The National Community Hearing Association (NCHA) represents community hearing care providers in Wales. NCHA members are committed to good hearing for all and have an excellent record of outcome, safety and patient satisfaction.

Our response

2. We welcome this inquiry to assess, in the context of major economic and strategic challenges facing the Welsh Government, the cost of caring for an ageing population[1].

3. We agree with the Parliamentary Review of Health and Social Care that ***"Wales needs a different system of care"***. We also agree that Welsh **services should be reorganised to meet the needs of patients and their families**, **easy to access, as close to home as possible**, **seamless and delivered without artificial barriers**[2]. These are unobjectionable goals for a system committed to serving population needs and developing a sustainable health and social care system. Unfortunately, these are longstanding and yet largely unachieved goals.

4. This is particularly the case in hearing care where need is growing but where, unlike the parallel services in eye care where the Wales Government has led the UK, the simple and obvious solutions have been eschewed and community providers unfairly excluded from the national debate.

5. Living longer and healthier lives is a sign of social progress and should be celebrated. Although we have improved life expectancy as a country, we have made less – and in many cases no – progress on active ageing. This means that **current health models are unsustainable and that they increase pressure on social care,** and therefore must change. The challenge of growing need needs should be reframed, for example
   a. there should be a focus on investing in active ageing rather than a – often negative – focus on the "cost of ageing"
   b. the "cost of caring for an ageing population" needs to focus on tackling risk factors associated with morbidities, especially long-term conditions and preventing them deteriorating, not just mortality.

6. At the heart of this is the **need to focus on improving quality of life and preventing premature decline.** In our response **we therefore use hearing loss and audiology as a prime example of the opportunity to improve access, outcomes and quality of life, whilst reducing avoidable costs associated with a population that is growing older.**

7. **Scale of the challenge:** unaddressed hearing loss is a major public health and financial challenge in Wales. There are an estimated 575,500 people with hearing loss and most have unmet needs[3]. Hearing loss is one of the most common long-term conditions in older people and as the population grows ages the number of people with hearing loss will increase.

8. **Impact:** Adult hearing loss is the fifth leading cause of years lived with a disability in Wales[4]. **Unsupported hearing loss significantly exacerbates the costs of health and social care**, for example it increases the risk of premature retirement[5], depression[6], social isolation[7]and loneliness[8], and reduces quality of life[9]. Research has also shown that unsupported hearing loss is associated with falls[10] and cognitive decline[11] in older people. Hearing loss can also lead to loss of employment[12], difficulties in finding employment[13] and reduced/unequal pay[14]. In contrast to expanded services in Wales for the parallel sensory impairment area of vision, individuals, the social care system and Welsh society itself is impoverished when people do not get the support they need for their hearing loss[15].

9. **Benefits of intervention:** fortunately, **early intervention and support for hearing loss can decrease pressure on health and social care by reducing the risks noted above**[16,17] and enabling people to age well. **Early intervention is especially helpful in supporting 'active ageing',** enabling older people to maintain their independence and remain, for those who are able, in the workforce for longer if they choose to do so.

10. **Solutions:** improving access to quality hearing care would improve patient outcomes and reduce medium to long-term financial pressures on health and social care[18] in Wales. More importantly it would improve the quality of life of older people in Wales, who will increasingly make up a larger proportion of society.

Given the scale of the challenge and affordable solutions, why is hearing loss an unaddressed challenge in Wales?

11. Although NHS Wales and Government published a plan in 2017 to better integrate hearing care services[19], many elements of this plan are unlikely to be delivered because the root causes of current system challenges remain unaddressed. For example
    a. the plan is not evidence-based and not related to population needs or risk. It is instead based on incremental and selective changes to existing models, largely influenced by existing professional groups and providers
    b. it does not fully address existing capacity issues and the need for more infrastructure, given the chronic nature of the main condition which the service will need to support
    c. there is no management imperative or additional funding to deliver change in non-medical adult hearing services, and therefore it is unlikely the changes required will be achieved.

12. In contrast, if an evidence and risk-based approach were taken, it would be clear that a different plan is required.

13. Given that alternative models of care will be covered by the Finance Committee's inquiry, we share lessons from other NHS regions here.

14. The NHS in England made a commitment to offer non-medical hearing care out of hospital and closer to home in 2007. Today 60% of the country offers adults the choice of accessing their entire adult hearing care pathway out of hospital. In contrast no meaningful progress has been made in Wales over the same time period. That is over 11 years of missed opportunities to transform local hearing services, improve access and reduce health and social care costs whilst supporting active ageing.

15. The NHS adult hearing service in England was reviewed by an independent regulator in 2015. The independent report found that when community-based capacity was added it encouraged all

providers (including incumbent hospitals) to provide adult hearing care closer to home, and also increased transparency, improved standards and provided value for money[20]. The review noted:

a. "*The introduction of [community based capacity[1]] has strengthened the opportunity for [the NHS] to achieve better value for money [and] often put in place more robust or higher service specifications that raise expectations of providers.*"

b. "*We estimate that the locally determined prices adopted by commissioners have been about 20% to 25% lower than the national non-mandated tariff. This can allow commissioners to treat more patients for the same spend and/or release additional funds that commissioners can spend on meeting other patients' needs.*

c. "…***making [adult hearing] services more accessible can help ease the longer term pressures on health and social services from unaddressed hearing loss*.**" [21] (our emphasis)

16. This and other evidence shows what can be achieved when service users and the public are put at the heart of planning health and care. It can also shift the focus away from 'the cost of an ageing population' to 'opportunities to help active ageing'.

17. Too often hearing loss is deemed a low priority in health care, yet the scale and impact of hearing loss on our ageing population challenges that longstanding bias. There is an urgent need to take an evidence-based approach to health and care reforms and put patients and the public, not the professions, first.

18. The vast majority of people accessing NHS hearing services today are aged 70 and older. **This review by the Finance Committee is an important opportunity to start taking this major public health issue seriously.** In doing so the Committee could demonstrate that active ageing is a viable strategy and avoid the biased trap of labelling our older population a cost burden. By targeting services like hearing care, and other sensory services, for reform we can deliver cost-effective and sustainable services to keep people well. **This will reduce social care costs associated with caring for an ageing population.**

19. If it is to be hoped that the focus and leadership of the Committee will stimulate more forward-thinking amongst the leadership of NHS Wales and Welsh Government officials. If it would be helpful to any AMs to visit a community hearing practice to see what can be achieved we would be happy to arrange this.

20. The NCHA is committed to working with Welsh Government and would be happy to expand on our submission if that would be helpful.

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[1] The report uses the term "choice" to refer to any qualified provider (footnote 2 of the report). In this case choice therefore means an explicit policy which stimulated the introduction of community-based hearing care.

References

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Consultation Response

Finance Committee Inquiry: The Cost of Caring for an Ageing Population

Evidence submitted by Age Alliance Wales

January 2018

Age Alliance Wales is an alliance of 21 national voluntary organisations committed to working together to develop the legislative, policy and resource frameworks that will improve the lives of older people in Wales.

The following 21 organisations represent Age Alliance Wales: Age Cymru, Age Connects, Action for Hearing Loss Cymru, Alzheimer's Society Wales, Arthritis Care, British Lung Foundation, British Red Cross, Care and Repair Cymru, Carers Wales, Carers Trust Wales, Contact the Elderly, Cruse Cymru, Deafblind Cymru, Disability Wales, Learning and Work Institute Wales, PRIME Cymru, RNIB Cymru, RVS Cymru, Sense Cymru, The Stroke Association, Volunteering Matters Wales.

Age Alliance Wales works with, and for, older people in Wales, and as such is pleased to be given the opportunity to respond to the Finance Committee's Inquiry into the cost of caring for an ageing population.

Age Alliance Wales has consulted with its member organisations in order to put forward their key comments. We are aware that two members, Age Cymru and RNIB Cymru, have submitted responses to the Finance Committee in their own capacity. It is not intended to repeat the contents of those responses within this report verbatim, but instead it will highlight some of the key points raised. For clarity, we have provided information in the format set out in the Terms of Reference.

1. **To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care**

As noted in Age Cymru's response, Wales Public Services 25 states that local authority spending on social care for older people is not keeping pace with population growth, requiring a 2.5% year-on-year increase until 2021 to return to a per capita spend equivalent to that of 2009-10. In real terms, since 2009 the per capita spend has fallen by over 12%[1] .

Similarly, RNIB Cymru's response to the Committee indicates that the ageing population will mean that the number of older people experiencing sight loss will

[1] Wales Public Services 25 (2017) A delicate balance? Health and Social Care Funding in Wales

increase significantly, with a doubling of people living with sight loss in Wales by 2050[2], a factor which may also significantly impact upon the costs of social care.

Age Alliance Wales members note that with an aging population comes a greater number of people living with co-morbidities and life limiting illnesses such as dementia, placing additional pressures on unpaid carers. It is therefore essential to ensure carers will be properly supported, and not be expected to sacrifice their own health, career or financial security in order to care for others, particularly as their assistance significantly lightens the workload of the health and social care systems. It is important to note that the carers themselves will also tend to be older than may have previously been the case, as pointed out by Age Cymru, particularly those aged 65+.

It is also the case, AAW members note add, that carers are increasingly relied upon to fill gaps in service provision, with fewer people being eligible for state-provided social care as time passes. Many carers, and those they care for, do not receive help until they are at a stage where their physical and mental health, and financial wellbeing, is severely impacted, requiring more costly interventions to remedy their situation than may have been required earlier. As such, AAW members would welcome a greater provision for older carers across Wales in order to ensure they achieve an acceptable quality of life, in terms of mental and physical health and wellbeing, and retain opportunities for social and financial inclusion.

2. **To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts arising from the UK leaving the European Union**

AAW members not there is an urgent need to ensure that social care receives adequate levels of funding, but historically it has been under-funded, a problem made even more prominent in recent years with reductions in public sector budgets. For example, RNIB Cymru's response notes that the government spends "relatively little" on health and social care services to support independent living by those with sight loss.

This problem has led to the practice of task and time based commissioning, shortening the visit times of domiciliary care workers significantly. Whilst AAW members have welcomed new Welsh Government legislation which should ensure sufficient time to provide care and support, it is felt that commissioning needs to shift to an outcomes-based approach, reflecting the intention of the Social Services and Well-being Act, if care staff are to be able to deliver good quality care and preserve the dignity of the person being supported.

The low payments made by local authorities to care providers can also impact upon recruitment and retention of staff, and their morale. Zero hour contracts and the minimum wage is widespread, undermining the ability to provide good quality continuous care, a problem that particularly affects those living with dementia. As

[2] Pezzullo L, Streatfield J, Simkiss P, and Shickle D (2016) The economic impact of sight loss and blindness in the UK adult population. RNIB and Deloitte Access Economics. Manuscript submitted for publication

such, AAW would back members' calls for commissioning processes to be led by people who have knowledge about, and experience of, personal care services.

There is a need to make the caring profession both more attractive and more competitive in comparison to the other sectors to which staff could be lost. Unfortunately it appears that the essential work of carers is not always recognised or appropriately valued, and whilst there may be means of valuing staff that go beyond pay, such as professional registration of domiciliary care workers and its potential to help enhance the status of carers' role in the eyes of the public, there remain questions as to whether this would be sufficient to make the role more attractive without also tackling funding and commissioning issues.

Further, members are supportive of the need to see the introduction of the Regulation and Inspection of Social Care (Wales) Act 2016 as a positive step to achieving higher quality sustainable care and support services for vulnerable people through a quality trained and committed workforce. To achieve this outcome, it must be recognised that pay, conditions of service, training and support for domiciliary care staff should not left to service providers to address alone.

We have concerns that recruitment of care staff will be more difficult to achieve if providers have to carry the upfront costs of training and we are even more concerned if these costs are transferred to services users.

3. **To consider the financial impact of current Welsh Government policies - including recent social services legislation and reforms to social care funding - on local authorities, care providers and service users**

Age Alliance Wales wishes to draw the committee to the individual responses given by its members regarding this point. However, we believe the committee may also be interested to hear of AAW's findings with regard to the impact of the Social Services and Well-being Act on service users.

During May 2017, more than a year after the introduction of the Social Services and Well-being (Wales) Act 2014, Age Alliance Wales launched the 'React to the Act: Older People have your say' survey along with the 'React to the Act: Professionals have your say' survey targeted at those working with older people.

These surveys aimed to capture the opinions, experiences and voices of older people, their families and their carers, on how the SSWBA had impacted on older people's lives and their experiences of accessing support and care services. It also aimed to capture the opinions of professionals working directly with older people requiring care and support following the implementation of the SSWBA. A number of key points can be found below:

- With regard to local authorities' assessment processes for people in need of social care, respondents indicated that whilst the majority of older people undergoing a needs assessment had successfully accessed appropriate

support services, over 30% of people had either not been able to access such services, or reported that services have subsequently ended. This indicates a significant gap in service provision, and the danger that many in need of care and support are simply not accessing the services they need.

- Survey responses indicated that although the legislation had led to changes in the assessment processes, there remains a need to continue to grow and embed this practice in order to ensure a consistent experience. It was found that just over half of older people reported being asked about 'what matters' during an assessment – a key point of importance in the Act - and a majority felt that they were 'fully' or 'somewhat' able to express their own views, wishes and feelings. Professionals' views in this area were more critical, however, with over half believing 'what matters' conversations were not taking place effectively with older people. Overall, it is believed these findings show further action is needed ensure consistency is achieved across Wales.

- Respondents indicated there is a lack of consistency in the monitoring and evaluation of 'person-centred care plans'. One third of older people had their plan reviewed on a regular basis, but nearly half stated they had 'not really' or 'not at all' had their plan re-evaluated. Professional opinion of performance in this area was even more concerning, with no respondents believing older people had their care plans reviewed on a regular basis, the majority stating that monitoring and evaluation did 'not really' or 'not at all' happen.

Signposting

Our surveys also indicated that local authorities' signposting to support services is inconsistent.

- Respondents indicated that signposting to other organisations for support is limited, with 44% of older people stating they were not directed to other organisations, and 5% reporting that they were directed but, in their opinion, the support did not meet their needs. Whilst there is the possibility that many older people were accessing appropriate support services elsewhere, and so do not need to be signposted to other organisations, or do not need such services, finding that 44% of older people are not being signposted by local authorities is concerning.

- Furthermore, whilst a significant percentage of professionals indicated that older people may be signposted, they are not always able to access those support services, with many indicating that they were aware of older people being signposted to services which were no longer operating.

Service Provision

- With regard to local authorities' provision of services, although only a small proportion of older respondents commented on the provision of services, those who reported witnessing a change in services as a consequence of the Act believed the changes had negatively impacted on the lives of older people. Older people also indicated a general increase in the levels of dissatisfaction in the standard of services they had received after 6th April 2016.

- Professional opinion on the provision of services was more divided: there was an equal number of those who had, and those who had not, observed a change in services that had directly impacted on older people. Levels of dissatisfaction in the standard of services available to older people, in professional opinion, had increased since April 2016.

Communication

- Respondents indicated a lack of communication which was sufficiently effective to ensure older people were made aware of how the changes made by the SSWBA will impact on them, their family members and their carers, with 76% of older people stating they had seen no information from their local authority.
- Just 31% of professionals believed the information provided by their local authorities, designed to enable older people to understand the changes brought about by the SSWBA, was “somewhat useful”. Essentially, this suggests local authorities have lacked effective communication with older people on these matters.

Advocacy

- The professionals and older people who had experienced a needs assessment or needs assessment review had varied opinions of the advocacy support provided during those evaluations. Of the professionals, there was an equal split between those who felt older people were given the opportunity of support from an appropriate ‘other’ or professional advocate, and those who believed they had not. Furthermore, 48% of older people who had experienced an assessment stated they had not been offered the support of an advocate, and 9% had been offered support but no suitable person or professional was available. Only 22% of older people stated that the opportunity had been offered and they had accepted (although there is no indication whether this was a family member or professional advocate).

Co-production

- Even though the Act requires local authorities to ensure service users have an input into service provision, survey respondents indicated this is not always the case: over half of older people, when asked if they had a say in their support services, said ‘not really’ or ‘not at all’, and only 10% said “yes fully”. Further, when asked whether older people have been empowered to have a voice in the support and services they received, no professionals believed older people ‘fully’ had a say, and 58% responded ‘no, not really’ or ‘no, not at all’.

4. **To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age;**

AND

5. **To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care. This will include the**

consideration of alternative models, including international examples, for the funding of social care to ensure a good quality, fair and sustainable service in a time of increasing demands on the health and social care systems

Age Alliance Wales would draw the committee to the responses submitted by Age Cymru and RNIB Cymru on these matters.

6. **To consider the findings and conclusions of the Parliamentary Review.**

In addition to the individual responses from AAW members, Age Alliance Wales would like to make a number of observations regarding the findings and conclusions of the Parliamentary Review, as contained in the January 2018 report:

We welcome the recognition of shortages of an experienced workforce, and the impact that has upon the delivery of health and care provision.

- Recommendation 1, aimed at ensuring a more seamless system of health and social care for Wales (whilst continuing to recognise the distinctions between the health and social care sectors), is welcomed, particularly its view that care should be organised around the individual and their family as close to home as possible. The smoothing of the artificial barriers between physical and mental health services, primary and secondary care and health and social care will greatly enhance the experiences of older people in Wales.

- With regard to Recommendation 2, that of pursuing a "Quadruple Aim" of four mutually supportive goals, this appears to be wise position to take.

- Recommendation 3's call for the speedier development, adoption and spread of a new models of health care and wellbeing appears prudent, particularly given the focus on making care available to individuals in their home surroundings or their community, as well as the suggestions to ensure the co-design and co-development of models of care between the recipients of care and frontline health and social care professionals.

- Furthermore, we welcome the requirement to ensure local innovation should be guided by "common principles and implementation support through a national programme of transformation, and robust evaluation", and support the calls for joined-up service provision, planning and infrastructure of resources in order to obtain a seamless delivery of care

- Recommendation 4's focus on strengthening the involvement and knowledge of communities and individuals of all ages in relation to health and social care provision is also welcomed, as is the call to ensure individuals have a greater level of decision making regarding their treatment and its location, not only for themselves but wider services within their communities.

We hope you find the comments of Age Alliance Wales useful.

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Inquiry into the cost of caring for an ageing population – Consultation Response

1. About the BDA Bwrdd Cymru and BDA Older People Specialist Group

1.1. The British Dietetic Association (BDA) as a whole is a professional body and trade union, founded in 1936, making it one of the oldest and most experienced dietetic organisations in the world.

1.2. The BDA Bwrdd Cymru is the board responsible for representing the professional, educational, public and workplace interests of dietitians in Wales.

1.3. The BDA Older People Specialist Group acts as a forum for the exchange of ideas, information and experience by dietitians working with older people and with an interest in the nutrition of older people.

2. Introduction

2.1. The BDA is grateful for the opportunity to respond to this consultation. In relation to the specific remit of the inquiry, the BDA wishes to raise the following issues:

- The current and future financial pressure on the social care system as a result of malnutrition[1] amongst older people in Wales.
- The demands on dietitians and dietetic support services in social care in Wales.
- To offer the BDA's perspective on the findings and conclusion of the Parliamentary Review.

3. Malnutrition

3.1. Extent and causes of malnutrition

Malnutrition is a problem across the UK and for a range of age groups, but it particularly affects older people. There are estimated to be around 1.3 million people aged over 65 with malnutrition or at risk of malnutrition in the UK, and the vast majority of these are in their own homes in the community – many of them unknown to healthcare services[i].

3.2. Analysis by the British Association of Parenteral and Enteral Nutrition (BAPEN) of data from nutrition screening from 2007-2011[ii] shows that;

- 25-34% of patients admitted to hospital are at risk of malnutrition – of which 80% could have been identified and treated in a community setting
- 30-42% of patients admitted to care homes are at risk of malnutrition

[1] NICE defines a person as malnourished if they have any of the following:

- a BMI of less than 18.5 kg/m^2
- unintentional weight loss greater than 10% within the last 3–6 months
- a BMI of less than 20 kg/m^2 and unintentional weight loss greater than 5% within the last 3–6 months.

- 18-20% of patients admitted to mental health units are at risk of malnutrition

3.3. Malnutrition can have a number of causes, and many cases of malnutrition in older people will be multifaceted.

3.4. Often, malnutrition is disease-related. People with long-term conditions such as kidney disease or chronic lung disease are particularly at risk of malnutrition, as are people with chronic illness such as cancer. Many conditions make it difficult or unpleasant to eat, due to vomiting or diarrhea for example. People with mental illnesses, such as depression, and neurological conditions, such as dementia, are also at greater risk, as they may have reduced appetite, poor mood or a reduced capacity to care for their own wellbeing. Conditions such as Crohn's disease, which disrupt the body's ability to digest food or absorb nutrients also raise the risk of malnutrition.

3.5. Poverty or concerns about affordability are also factors; a report by CEBR for Kellogg's found that on average retired households spend the second highest proportion of gross income on food and drink; 11.2%[iii]. The average annual food bill for a retired household has increased by over 12% from 2012-2017. Indeed, CEBR stated in 2013 that as many as 1.5million over-65s[iv] were in food poverty – defined as spending more than 10% of household income on food.

3.6. Access to food can also be problematic, even when affordability is not an issue. Age UK's Food Shopping in Later Life report highlighted significant numbers of people over 65, and particularly over 80, who struggle to access shops, or have difficulty in-store or with packaging[v]. For elderly people particularly, loneliness and social isolation are a risk factor for malnutrition. According to Age UK, more than two million people over 75 live alone, with many going long periods with little or no social contact[vi].

3.7. Difficulty eating or preparing food for whatever reason is another factor. This can include issues such as swallowing difficulties, mobility issues or problems with teeth or dentures. Even in healthcare settings, people can face problems with accessing food. The latest Adult Inpatient Survey in England (2016)[vii] showed that 17% of patients reported not getting enough help from staff to eat their meals. This figure has improved from 2006, when 21% of patients reported not getting enough help.

3.8. Impact and cost of malnutrition

The impacts on health of malnutrition can be wide ranging, especially amongst elderly people. They include;

- increased risk of illness and infection and slower wound healing
- increased risk of falls
- low mood
- reduced energy levels and muscle strength
- reduced quality of life and independence.

3.9. Data from Marinos Elia's report for BAPEN[viii] on the cost of malnutrition in England in 2011/12 has more recently been extrapolated to the whole of the UK for 2016, in figures presented to the BAPEN Annual Conference. **These figures estimate the cost of malnutrition in Wales to be more than £1.4 billion per annum.** These costs include impacts on all health services, from acute hospital care through to social care in the community.

3.10. We know that older people with malnutrition make much higher use of healthcare services – they are twice as likely to visit their GP and will have more frequent and longer hospital admissions. It also increases their risk of developing co-morbidities[ix].

3.11. Tackling malnutrition

Properly treating malnutrition is a highly cost effective intervention. Nutritional support in adults was ranked as the third highest cost saving intervention (£71,800 per 100,000 general population), associated with implementation of NICE Clinical Guideline (CG32)/Quality Standard (QS24)[x].

3.12. In order to tackle malnutrition we must ensure that everyone has access to a nutritious, high quality diet that meets their individual nutritional requirements and for those unable to meet their nutritional requirements through food alone to have timely access to nutrition support. Systems must be in place in community health and social care settings to identify and support those at risk of a sub-optimal diet and hydration.

3.13. Dietitians play a significant role in the treatment and management of malnutrition in a range of settings. Evidence shows that dietetic care, delivered as part of multidisciplinary approach, is both clinically effective[xi] and cost effective[xii] in the management of malnutrition. Dietitians also have the skills to train other healthcare professionals to identify the risk of malnutrition, and work with a multidisciplinary team to increase nutritional intake and promote weight gain.

3.14. Dietitians should lead the coordinated and integrated approach to addressing the nutritional care of vulnerable populations, including elderly people, in community health and social care settings. Dietetic-led nutrition support services are best placed to develop and initiate the correct evidence-based nutritional care policies and guidelines and ensure that those at risk of malnutrition (whether social or disease-related) are identified and managed appropriately; including those individuals with psycho-social related malnutrition.

3.15. The BDA believes that service commissioners must recognise the value and potential cost savings of preventing malnutrition and therefore commission services that ensure all people identified as being at risk of malnutrition are offered nutrition support interventions that meet personalised nutritional requirements.

3.16. More information on these recommendations is available from the *BDA Policy Statement on the Management of Malnourished Adults in All Community and All Health and Care Settings*[xiii].

4. Demands on Dietetic Services in social care

4.1. As of November 2017, there are approximately 500 registered dietitians in the whole of Wales, spread across acute, primary and community services, as well as public health, industry and freelance roles. Given the scale of the challenge of malnutrition amongst older people alone, the BDA would argue that the number of dietitians needed to ensure appropriate care in both the community and acute sectors must increase if we hope to ensure a good standard of nutrition care amongst the growing ageing population of Wales.

4.2. Our members have reported to us that trusts have recognised a lack of specialist staff available to provide care to Wales' ageing population. For example, Abertawe Bro

Morgannwg UHB has raised specific concerns regarding the services for patients with dementia, and in particular the lack of dietetic provision to the specialist inpatient old age psychiatry department. More generally the health board has placed the nutrition and dietetic workforce in mental health on the board's risk register.

4.3. Nutrition Skills for Life[xiv] is a national programme, run by dietitians, which seeks to equip staff working with vulnerable older adults with the nutrition knowledge and skills to improve food and drink provision for those in their care and prevent malnutrition. This has been very successful, but its delivery continues to be inconsistent across Wales, with some areas having much greater support and access than others.

5. Findings and conclusions of the Parliamentary Review

5.1. The Parliamentary Review published in January 2018 utilises care for older people as an example of how "seamless models of care and support" in Wales might work. It identifies a need for coordinated community, primary and secondary care services with a focus on prevention and early assistance, delivered by multidisciplinary teams of well supported health and care professionals. Dietitians need to be a core part of this, both to help deliver direct interventions and to ensure that the wider health and social care workforce have the skills to prevent, identify and treat malnutrition and other conditions where nutrition is an important factor.

5.2. Such seamless models certainly have the capacity to produce real improvements in patient outcomes while also making better and more efficient use of the NHS's precious resources. However, it will require initial investment and ongoing support of the workforce if it is to happen with the speed and consistency that is required. This is recognised within the Review, but must be backed by the government in its future spending commitments.

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[i] http://www.bapen.org.uk/malnutrition-undernutrition/introduction-to-malnutrition?showall=&start=4
[ii] http://www.bapen.org.uk/malnutrition-undernutrition/introduction-to-malnutrition?showall=&start=4
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The promise of social care

Why Wales needs a community insurance fund and how to organise it

Gerald Holtham
Hodge Professor of Regional Economics

Social care, particularly for the elderly faces a serious squeeze in Wales, not to say a crisis. Local authority spending per older person has declined over the last seven years by around 13%, according Wales Public Services 2025. The proportion of elderly people in the population requiring residential care is projected to rise by 82 per cent by 2035 and the proportion requiring non-residential care to rise by 67 per cent. Expenditure overall will need to rise by 75- 80 per cent to account for that and if the recent deterioration in spending per head is to be reversed spending would need to double. That is consistent with the finding of the Health Foundation which concluded that adult social care funding in would need to rise by 4% in real terms each year for most of the next two decades. Meanwhile the Welsh budget under austerity will probably grow much slower than that.

Absence of adequate social care provision not only leads to suffering in itself but often shows up as a crisis in the health service. Elderly people with chronic conditions end up in hospital and stay there because there is nowhere where they can be safely discharged. That creates a pressure on available beds triggering problems elsewhere in the health system. It also results in time-consuming, invidious haggling over resources between health and care service personnel.

If social care is to be provided in old age in Wales at a civilized level without commandeering the assets of many elderly people, a new source of revenue is required. If the UK government devotes more resources to social care more money would become available to the Welsh government via the operation of the Barnett formula but this would be unlikely to be enough. The best means of obtaining the required revenue is through public participation in a new contributory scheme of compulsory insurance. A very small levy on Welsh residents could feed a dedicated social security fund that meant everyone could be promised adequate social care in old age – a promise that cannot otherwise be made or kept. The scheme should not only be contributory but also funded, rather than "pay as you go" in the more traditional ways of British public finance, whereby all pay-outs come from current contributions or tax receipts..

There are several compelling reasons why the scheme must be both contributory and funded. It must be contributory because that will ensure readier public acceptance than a tax increase that provides social care to all people in Wales indiscriminately. Contributions

can be recorded in personal accounts that show people the extent of their entitlements. It must be funded because the main demographic burden lies 10 to 20 years ahead and a pay-as-you-go scheme would require rising contributions and would be necessarily unfair in its treatment of different age cohorts. Moreover, the public is more likely to accept another impost if the proceeds are hypothecated to a service that it appreciates. Hypothecation is just a word, however, without a dedicated fund to accept contributions and disburse payments. A funded scheme is therefore much more likely to enjoy public support. And the fund would have other great benefits because it would have to be invested and could be used to promote other social objectives, for example social housing construction and boosting the growth of promising Welsh businesses.

The case for contribution

Experience shows that it is difficult to maintain an advanced welfare state that has substantial elements of redistribution in a country with open borders and extensive immigration. The United States, for example, a country built on immigration has always had meagre welfare provisions by the standards of rich countries. The most advanced welfare states were developed by small homogenous countries like Sweden and Austria at a time when immigration was insignificant.

In the UK, opinion surveys have charted a marked decline in public support for "welfare" and declining sympathy with the disadvantaged in recent years at the same time as concern has grown about accelerated immigration. Much of this concern is expressed as resentment of competition for public services and a belief that immigrants are entitled to social security benefits before they have made much contribution to the system. The latter concern demonstrates that the public retains a strong attachment to the contributory principle. The same attachment feeds into to the popularity of hypothecated taxes. People like to know where their taxes are going and to feel that they will derive the benefit of their payments.

These public attitudes are of direct relevance to policy in Wales. The Brexit vote probably indicates that the Welsh public shares many of the concerns and preferences of the UK public as a whole. Overseas immigration into Wales is not high but 25 per cent of the population was not born in Wales; most incomers were born in England. If the Welsh public and politicians wish any element of the welfare state to be more generous in Wales than it is in England, how can this wish be fulfilled, given that there is – and will remain – complete freedom of movement and residence across the Wales-England border? The only answer lies in the contributory principle.

If the Welsh public pays for enhanced social care in old age, for example, that care must be available only to Welsh residents who have made enough payments into the scheme. The English system may cap the amount that the elderly have to pay for care before the state picks up the tab and it means tests the individual for the assets they have that could be sold to finance care. If Wales wishes to improve on those conditions (and maintain them in a period of demographic stress) it must do so through a contributory system. For people who have not made contributions the default position must be no better than that applying in England. Parity of provision means people are not penalized for retiring to Wales but nor are they rewarded.

Social care is currently paid from local authority budgets and these are determined by the Welsh government from its budget, which is largely determined by the Barnett formula. That formula takes no account of Welsh needs and its effects can be perverse. Suppose, for example, that a substantial proportion of the elderly in Lancashire retire to North Wales, English formulae might reduce grants to Lancashire local governments on the grounds that their needs had decreased. There would be no commensurate increase in the Welsh block grant, however, which is not needs based. In those circumstances it is absurd for Wales to promise better social care for the elderly to people retiring from England. Not only is it unfair to Welsh contributors but it incentivizes more elderly people to move. A non-contributory system of social care in Wales if it offered better conditions than in England could turn parts of the country into a retirement home.

The Welsh public is much more likely to support paying for enhanced social care in old age if they know benefits are not leaking to non-contributors on a significant scale.

Support is also more likely if the scale of individual contributions is seen to be fair. There is plenty of evidence that the public relates fairness to ability to pay. It would generally be regarded as fair if contributions were related to income. As with any insurance system, benefits are largely a matter of chance. If someone remains healthy and independent until death they will not draw on social care benefits, however much they have contributed. Most people would regard someone with that fate as fortunate rather than unfortunate. It is good to be insured and better never to have to draw on the insurance. "From each according to his ability, to each according to his needs" is one socialist principle that therefore enjoys widespread support in the context of national insurance.

Fairness, however, dictates that people with similar lifetime incomes should make similar contributions for the same promise of care in old age. That has clear implications for inter-generational fairness. When a fund starts up, a young person will pay in for perhaps 40 years. Someone aged 55 with the same income may pay in for ten. Obviously they cannot be expected to pay in at the same rate.

How it could work

*Let us suppose that paying in begins at age 21 and continues until the future state retirement age at 67, that is 46 years (these numbers can, of course, be altered). Now consider someone who begins paying at the age of 27, (because they are that age when the scheme starts or because they finish education or move to Wales at that age after the scheme has started). That person will pay for 40 years. Let us suppose that their payment is x per cent of income. Someone on the same income who is 57 when the scheme begins will expect to pay for just ten years, not 40, so they should pay not x but 4x per cent of income. We can apply that principle generally. If someone starts paying at a given age, ϑ, they will pay a proportion of income equal to: 40/(67-ϑ) * x. For example, someone who starts paying at age 47 pays 40/20*x, that is to say pays twice the rate of someone starting at 27. A 21 year old would pay 40/46*x, that is 87 per cent of the 27 year old. What might this mean in practice? Suppose someone at 57 pays two per cent of income, the 27 year old would pay ½ per cent and so on.*

Note that these rates pertain to the age at which payment begins. The people in a given age cohort pay at the same rate throughout their contributing life. Contributions rise with the age at which you start; they do not

rise for the individual as she gets older. Note as the scheme matures and older cohorts retire, most people paying in will have started earlier and the disparity of rates paid will diminish.

Such a scheme poses several questions:

- *What about people who leave Wales to work elsewhere and then return?*

  *Someone's contribution age would be adjusted for periods of non-payment. Consider, for example, someone who started work at 23, left Wales at 30 and returned at 50. Their target contribution is 40 years at x per cent of income. They will in fact have an expected 17 years left to contribute and have already contributed 7 years at 90 per cent of x (the rate for a 23-year-old starter). The new rate they pay at 50 is (40-6.3)/(67-50)*x = 1.98. That is to say they would resume payment at nearly twice the rate for 27 years-olds. On the above example they would pay 0.99 per cent. Alternatively, they could opt to continue payments while not in Wales if they intended to retire here. There would have to be a system able to collect and process such payments*

- *What about people who retire before 67?*

  Early retirement for genuine reasons of ill health or incapacity would not affect entitlement. Voluntary early retirement could be dealt with in one of several ways. Firstly, the person could be required to maintain payments out of pension income until age 67 in order to retain full entitlement. Failure to make such payment could result in a reduction in entitlement. The nature of that reduction would depend on the detailed care promise that is made to participants in the scheme. A full answer must be deferred to discussion of the promise.

- *What about people who leave Wales after contributing?*

  If people leave and retire elsewhere without completing the full target contribution of 40x times income, they abandon their entitlement. If moving at a late stage with most contributions made, they could retain entitlement on payment of the appropriate cash sum. If they complete the full contribution and then retire elsewhere, they would retain the right to a cash contribution to bona fide care costs. The payment would depend on the general care promise and the costs of care in Wales. The insurance fund would not make any allowance for different care costs in other places.

- *What about people over 57 now, who will not be able to make sufficient contributions to qualify for the care promise under the scheme?*

  Here there is a serious political question to be decided. How much of a transfer should younger age cohorts make to the care of today's elderly above and beyond what is being done already via taxation? We suppose that some minor proportion of contributions would go to the immediate improvement of social care. That proportion should be analysed in terms of the optimal growth of the community insurance fund - by comparing the social care promise that can be made to long-term contributors to the fund with the level of provision being experienced at present and in the next few years. That remains to be done in detail. If immediate improvements in care are modest, workers expected to retire in the next few years would be exempted from payments or contribute at a lower rate.

- *What about the unemployed or people on benefits?*

  Their contributions would be paid as part of the benefit system. If they are entitled to benefits, they are entitled to be included in the scheme. It will be a political choice whether the Welsh government pays the full contribution on top of existing benefit or whether it expects benefit recipients to make some contribution out of the payments they receive. There is also the issue of people not in

employment or in receipt of benefits such as house-spouses who care for a home or family and are supported by a working spouse. One possibility is a family contribution rate. A worker could opt to pay a supplement, say 50 per cent more, to their contribution to cover a live-in partner.

The case for a funded scheme

While the state in the UK does not maintain funds to support its pension or social security obligations, it is common practice to do so in other countries, like Japan and Canada. Local authorities, of course, maintain pension funds to cover obligations to their workers. A funded scheme will enable the government to set a contribution rate now in the expectation that it can be held constant even as the demographic situation deteriorates, which would be difficult with pay-as-you-go. It also makes it easier to maintain equity between generations or age cohorts. Those elements will make the contributions more acceptable to a sceptical public. Moreover, as noted, the existence of a fund makes hypothecation of revenues concrete and further boosts public confidence.

Finally having a fund is an act of public saving that can have other beneficial consequences. The fund must be invested in order to grow. In effect it becomes a community fund or sovereign wealth fund. Most of its assets must be safe, traded assets like quoted bonds or equities that can be realised easily. A small proportion, however, can be invested in projects with social utility in Wales – like building low-cost housing or investing in local companies. Wales like the UK as a whole does not save enough. That is why the country runs an external deficit and has relatively low investment rates. The social care fund would contribute to alleviating that problem.

Managing a Social Fund

The objective is to be able to spend the requisite amount on social care for the elderly in the future. Current spending by local authorities is around £550 million a year. Assuming public spending on care matched Welsh government revenue growth, we supposed this would increase at an annual rate of 1.5 per cent above wage growth. This is an assumption which implies some continuation of public sector austerity through the 2020s. Demographic projections imply care spending should rise by 80 per cent in real terms by 2035. That plus the desire to restore a 13 per cent decline in care spending per head in recent years, together mean that total spending must grow at 4 per cent. It would need to double by 2035, while public spending would increase by only some 30per cent. To fill the gap the fund would have to contribute £400 million a year in 2035 at 2017 prices.

If we assume the tendency to an ageing population is peaking in 2035, the annual payout need not grow much thereafter but it could still be necessary for the fund to contribute £400 million a year at constant prices for decades. If contributions are being received from younger workers in return for a care promise, that promise has to hold good indefinitely, at least for some 70 years from the present day.

Given that each age cohort pays in at a different rate and the older cohorts pay more, the average contribution rate will fall over time as the older cohorts retire. Contribution rates have to be set so the fund is sustainable. Essentially that means when the contributions into the fund are subtracted

from the £400 million it pays out to get the net outflow from the fund, that outflow must not exceed the growth rate of the fund. If the fund's investments mean it is growing at, say, 5 per cent and the final annual contribution is £200 million a year, the net outflow of £200 million must not exceed 5 per cent of the fund. In other words, the fund in this example must be at least £4 billion.

We use simulations to explore different contribution rates to the fund and different disbursement rates from it. We assume rates of contribution that broadly follow the formula for variation with age outlined earlier. However, strict inter-generational equity would mean very steep increases for older cohorts. Someone aged 57 with 10 years to pay would pay only half as much as someone aged 62 with five years to pay. That seems too steep a rise for those nearing retirement especially since payouts from the fund will not be so large in the early years. We therefore suppose there is a ceiling on the contribution rate around age 60. We further assume that a top contribution rate of 3 per cent is the highest politically acceptable. That implies 27 year-olds would be paying at a rate of 0.7 per cent and the weighted average contribution rate for the whole labour force would be just under 1.5 per cent. That would fall over the decades to around 0.6 per cent. We test whether these rates lead to a sustainable system. Obviously, variations are possible implying some departure from strict intergenerational equity.

Apart from setting rates that are reasonably fair to different generations and that make for a sustainable system, the government and trustees of the fund must decide how much of any inflow should be dedicated in year one to an immediate increase in spending on care and how much retained and invested to grow the fund. Given an annual inflow from levied contributions to the fund, the question is how much should be disbursed immediately for social care and how much invested for future requirements. Since the amount to be disbursed in 2035 is predetermined at £400 million, setting the initial disbursement in year one also determines how fast that disbursement has to grow to reach the 2035 figure. The disbursement and its growth are a policy pair that has to be set.

Simulation assumptions

We assume the scheme begins in 2019 and test options by simulating their effects. We need stochastic simulation because we do not know with certainty what investment returns will be over any given time period.

For the simulations we assume the investment returns to the fund are random and normally distributed with an average of 5 per cent a year and an annual standard deviation of 7.5 per cent. These numbers are selected on the basis of their reasonableness, being slightly below the long run averages for equity markets. They are, however, inconsistent with a belief in secular stagnation of the world economy. We assume the fund would be invested in , blue chip equities with some government bonds and small holdings in public housing and Welsh private equity.

To make the simulations we need to project the revenues arising from different contribution rates. These will depend on the evolving age structure of the economically active population. We take population projections by age published by the Welsh government. We also have data for the economically active population or labour force. We assume the relation between the population and the labour force is stable for each cohort, enabling us to estimate and project the labour force forward. We have data from HMRC for the UK as a whole of income by age cohort. We assume the ratio of the average income for each cohort to overall average income is the same for Wales as the UK and is also stable over time. We ignore the overall growth of wages over time because we assume care costs rise at the same rate as average wage income, enabling us to ignore the growth

of both. These data and assumption enable us to project the revenue that will accrue over time for any set of contribution rates as the population evolves.

Evidently the results of simulations are dependent on these assumptions.

Simulation Results

The objectives of the fund are firstly to be able to disburse a meaningful amount of money to social care from the outset and that this amount should grow to some £400 million a year by the early to mid 2030s. A second objective is that the fund should reach such a size that when contributions have settled down the net payout from the fund should be sustainable indefinitely, i.e. outflows should not exceed the growth of the fund.

If the fund were to disburse £135 million in its first year it would restore at a stroke the 13 per cent decline in care spending per head since 2009. It turns out that for this to be probably sustainable, the minimum contribution to the fund for any age cohort would have to be set at 1 per cent. Since the top rate is assumed to be 3 per cent, that would entail some transfer from younger to older cohorts. If strict age proportionality of contributions were preserved the minimum contribution for working teenagers would be 0.56 per cent, given a 3 per cent ceiling for those at 57 and above. In that case, sustainability would be very hard to achieve. It would require the fund to reach some £5 billion by 2035. The initial disbursement in this case would have to be low. With a disbursement of even £50 million initially, the fund would not be expected to reach £4 billion in 2035 and in the worst case might be only around £1 billion. Moreover it would then fall.

To sustain an initial disbursement of £50 million, (an increase of nearly 10 per cent on current LA spending) the minimum contribution to the fund would need to be set at 0.75 per cent at least. That is, those beginning in the age range 18-27 would pay 0.75 per cent and the contribution would rise with age cohort to 3 per cent for those aged 57 and above - there would be a ceiling at that level. The initial disbursement could not be higher unless the minimum contribution rate were raised. Even then there could be a shortfall if investment returns were poor. If the minimum contribution were set at 1 per cent, higher disbursement rates would be possible

Simulation results show that a payout of £80 million with a minimum contribution rate of 1 per cent would leave the fund with an expected value of £6.1 billion in 2035 with a worst case value of £2.2 billion. While risks would remain from low investment returns, that seems a reasonable compromise.

To compare the consequences of different policy pairs we look at three variables, one is the cumulative spend on care over the whole period to 2035; two is the terminal value of the fund in that year. A third variable which we call utility combines a number of considerations; it takes the discounted cumulative spend on care, the discounted terminal value of the fund and the discounted sum of investments that the fund is presumed to make in social housing and Welsh venture capital and weights them together. We assume rather arbitrarily a social discount rate of 6 per cent in calculating utility. We tested this for sensitivity and found variation of the discount rate between 4 and 6 per cent had no effect on the ordering of policy pairs.

For a number of policy combinations we ran a stochastic simulation where the return to investment in the fund was a random variable drawn from a normal distribution as noted above. The simulation

was repeated 10,000 times for each pair and the average value and minimum value taken for the three variables of interest. Some results are shown in the attached table on the next page. Their main features are as follows: utility as we have defined it goes up as the initial annual disbursement goes down for low levels of minimum contribution. For example for a minimum contribution rate of 0.75 per cent, it is higher with a £40 million initial payout than for a £50 million initial payout. However, when the minimum contribution rate is raised to 1 per cent, utility rises with the initial payout, all the way to an initial £135 million. Whether this is really the best policy, however, depends on how one balances higher payments for care in the early years against a larger terminal fund with the concomitant greater capacity to sustain the same or higher spending after 2035 and less risk of a shortfall requiring an injection of funds.. If social care is being supported on the contributory principle, the later payments to people with a full payment record must be at least as good as immediate payments which are being received by people who have not had the chance to contribute. A larger fund also implies greater investment in social housing etc.

Monte Carlo analysis therefore implies that policy-makers should lean towards setting a minimum contribution rate for youngsters of 1 per cent, departing from strict age-proportionality of contribution. An initial allocation to care spending, can then be set anywhere in the range £50-135 million.

People over 57 will make a smaller contribution to the fund than younger citizens and those over 67 will make no contribution at all. Full contributors will typically start to need care in 20 years' time or more. At an initial annual payout of £50 million, conditions would improve but the 13 per cent per capita decline in care since 2009 would be made good completely only after some 12 years. While the existing elderly would benefit from an immediate 10 per cent increase in expenditure on care and improved conditions thanks to the payments into the fund (there would be some income transfer between age cohorts) they might not enjoy quite as good conditions as later cohorts who have paid in. That seems to be consistent with the contributory principle. The precise scale of intergenerational transfer is, or course, a matter of political choice. That choice will determine the initial payout in the £50 million-£135 million range. But the higher it goes the greater the risk of an investment shortfall requiring increased contributions later to preserve the integrity of the contributional scheme.

Simulation Results

min 1% contribn, initial payout £50m		
Simulation results	average	minimum
utility	1511	1061
cumulative spend £'000s	-2818	-2818
fund value 2035 £'000s	7101	3015
fund value 2039 £'000s	8184	2925

min 1% contribn, initial payout £135m		
Simulation results	average	minimum
utility	1605	1061
cumulative spend £'000s	-4163	-4163
fund value 2035 £'000s	4966	1861
fund value 2039 £'000s	5505	1652

min 1% contribn, initial payout £80m		
Simulation results	average	minimum
utility	1587	1020
cumulative spend £'000s	-3478	-3478
fund value 2035 £'000s	6117	2197
fund value 2039 £'000s	6855	1904

min 0.75% contribn, initial payout £50m		
Simulation results	average	minimum
utility	1248	775
cumulative spend £'000s	-2956	-2956
fund value 2035 £'000s	4555	1452
fund value 2039 £'000s	4655	731

min 1% contribn, initial payout £100m		
Simulation results	average	minimum
utility	1602	1074
cumulative spend £'000s	-3731	-3731
fund value 2035 £'000s	5688	2254
fund value 2039 £'000s	6368	1457

min 0.75% contribn, initial payout £80m		
Simulation results	average	minimum
utility	1253	782
cumulative spend £'000s	-3478	-3478
fund value 2035 £'000s	3731	1208
fund value 2039 £'000s	3644	429

Note: The three simulations in the first column are of a minimum contribution of 1 per cent with different initial pay-out rates. All appear to be sustainable unless investment returns are extremely poor. The first simulation in the second column shows the consequence of a higher initial pay-out of £135 million, which also seems to be sustainable though the error margin is less.

The next two results have a lower minimum contribution rate of 0.75 per cent. That with an initial pay-out of £50 million may be sustainable but there is a high risk further contributions would be required. The final simulation with an initial pay-out of £80 is not a sustainable plan. The fund does not reach the level of £4 billion needed to be sustainable at these contribution rates and falls after 2035.

What would the care promise be?

A contribution averaging 1.5 per cent across the age cohorts would mean the mean wage earner paying about £450 a year or £9 a week. Contributions would differ with age. 27 year-olds would pay 1 per cent and 57 year-olds 3 per cent, the top rate. The contribution could raise expenditure per head by at least 10 per cent immediately, enabling standards of care to improve and nursing homes

to be more viable. The increment to funding would grow at double digit rates enabling expenditure per head to return to 2009 levels in 10-12 years from the start of the fund while accommodating expected increases in demand owing to population ageing.

Together with recently announced increases in Welsh government spending we believe the means test on asset values could be raised substantially. The Welsh government has promised to raise the asset value beyond which public care support is not available to £50,000. That is widely regarded as inadequate when the average house price in Wales is £175,000. The Welsh government may also receive more money via the Barnett formula if the UK government increases spending on social care for the elderly. Without knowing what the normal Welsh budget would be we cannot say what precise promise on care for the elderly could be.

The Dilnot Commission in England recommended a cap on private expenditures on care to protect people from the effects of catastrophic bills resulting from prolonged infirmity or acute illnesses requiring expensive specialised care. Provision for the latter is necessary to relieve the health services of the consequences of inadequate social care provision and consequent bed blocking. It is difficult to obtain private insurance against catastrophic bills so this is a worthy objective and use of public money. The social care fund would permit a lower cap, more generous means testing or even largely free social care depending on other budgetary provision.

Conclusion

More work is required, of course, to settle details but these initial explorations suggest it is feasible for Wales to create its own social security fund to enable enhanced public provision of residential and non-residential care for the elderly. A minimum contribution rate of 1 per cent would be levied on the incomes of those entering the scheme at age 27 or less. Contributions would rise with age cohort to a ceiling of 3 per cent for earners aged 57 and above. This would provide enough funds to improve care provision immediately by at least 10 per cent and deal with the expected demographic shifts towards a more elderly population. It would also raise the national savings rate and provide a community fund of several billion pounds by the 2030s. That in turn would facilitate ongoing investment of tens of millions of pounds a year in worthwhile, cash-positive investments in Wales. This approach plans for a future in a way that reflects the motivation of the 2015 Wellbeing of Future Generations Act of the Welsh National Assembly.

Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Response from the Older People's Commissioner for Wales

to the

National Assembly for Wales' Finance Committee Inquiry into the Cost of Caring for an Ageing Population

January 2018

For more information regarding this response please contact:

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About the Commissioner

The Older People’s Commissioner for Wales is an independent voice and champion for older people across Wales, standing up and speaking out on their behalf. She works to ensure that those who are vulnerable and at risk are kept safe and ensures that all older people have a voice that is heard, that they have choice and control, that they don’t feel isolated or discriminated against and that they receive the support and services they need.

The Commissioner's work is driven by what older people say matters most to them and their voices are at the heart of all that she does. The Commissioner works to make Wales a good place to grow older - not just for some but for everyone.

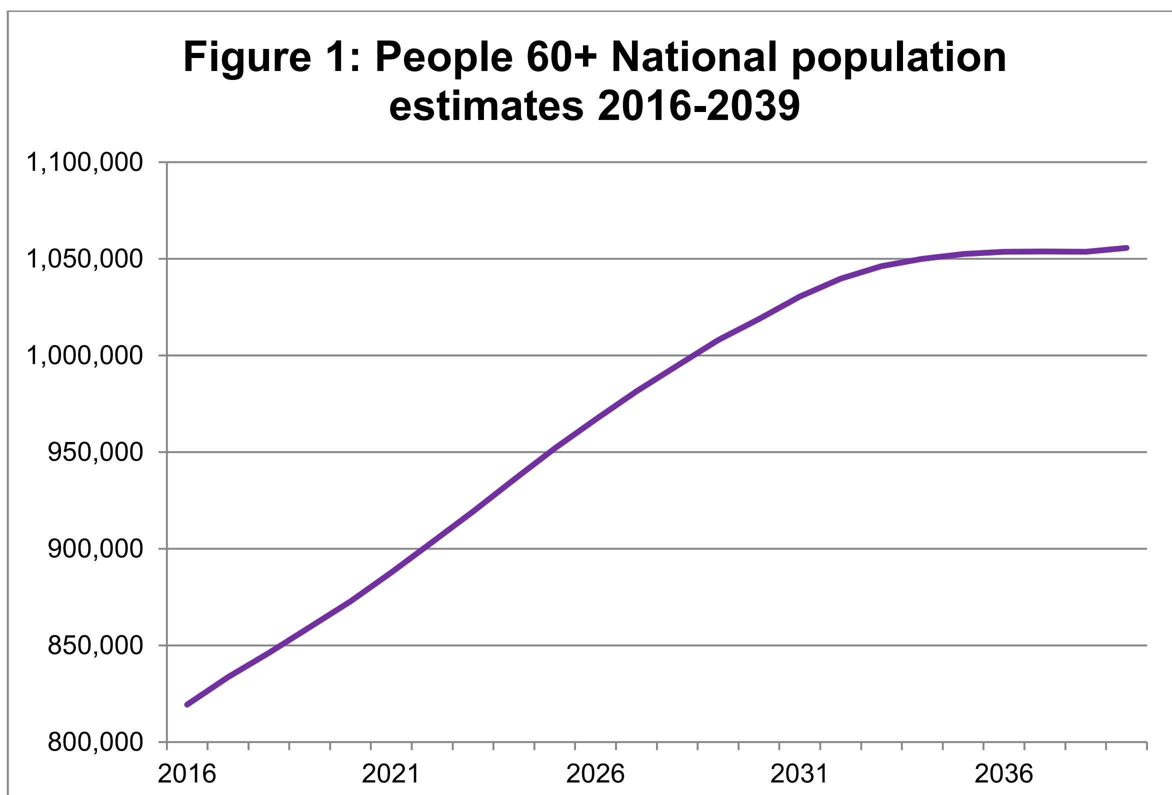
The Older People’s Commissioner for Wales:

- Promotes awareness of the rights and interests of older people in Wales.
- Challenges discrimination against older people in Wales.
- Encourages best practice in the treatment of older people in Wales.
- Reviews the law affecting the interests of older people in Wales.

Introduction

1. Wales is a nation of older people. Of a population of over 3.1 million, approximately 800,000 are over the age of 60.[1] It is also a nation with a significant number of 'older older' people, i.e. those over the age of 85. Parts of Wales, such as the north and the south Wales valleys, have some of the highest levels of older people within the UK.

2. This proportion has been significantly increasing over the past decade and is set to continue to increase until the 2030s, when demographic projections indicate that this increase will begin to slow (Figure 1).[2] Researchers from Newcastle University have shown that whilst we will be living longer than ever before, there will be a considerable increase in the number of older people living with multiple diseases.[3] 'Healthy' life expectancy increases are not keeping pace with the increases in life expectancy.



3. Whilst infirmity and decline should not automatically be assumed as an inevitable part of ageing, there are a range of indicators about the current population of older people that have an impact upon their use of public services. More than two thirds of older people live with a

long standing health condition,[4] half have a life limiting disability, one in six live in poverty,[5] over 40,000 are victims of domestic abuse every year,[6] over 7,500 are the victims of financial crime each year[7], significant numbers are lonely and isolated,[8] and over 45,000 have a form of dementia.[9]

4. The majority of older people continue to live in their own homes but as time goes on, they will require increasingly complex and time-intensive packages of support, often from a wide-range of agencies. Older people will often need support for activities such as bathing, washing, eating, dressing, taking medication and the wider monitoring of their physical, mental and emotional health. They will also need support to ensure that they remain included within wider society, including mobility support to enable them to continue to go out and social support to retain their connection to their communities.

5. Some older people will be able to remain in their own homes but will be dependent on support from family members and unpaid carers. The contribution currently made by unpaid carers is estimated at £8bn a year within Wales, more than the total spent annually on health and social care services.[10] A study published in 2015 predicted that the number of people needing care would outstrip those 'available' to provide it by 2017.[11] Furthermore, of six million people in the UK caring for an older relative, over two million are themselves aged over 65, with more than 400,000 over 80 years of age.[12]

6. Significant numbers of older people will eventually not be able to remain in their own homes, moving into extra care or into the care home sector. The physical and emotional needs of people living within these sectors have increased significantly and rapidly over the last five years and will continue to do so.

7. Research has shown that both the domiciliary and residential care markets are very fragile and we do not yet have a sufficiently clear picture of what the level of demand for these services will be. Shortfalls in service provision have cost implications, for example in relation to creating a greater need for unscheduled care and delaying

discharges from hospital, as well as undermining the achievement of overall wellbeing outcomes for individuals.

8. Older people are also significant users of healthcare services. Primary care is the first port of call for many older people with approximately 80% of contacts taking place in this sector.[13] Older people want to have care provided as close to home as possible, for reasons of accessibility and person-centred care. It is essential that action is taken to ensure a holistic approach to older people's physical and emotional health and wellbeing. It is clear from my report into older people's experiences of accessing and using GP services in Wales that older people face a number of challenges in accessing services within primary care at a cost to both them and the public purse.[14] Unscheduled care is also a significant issue for older people, particularly accessing inpatient services via A&E. These also have a cost to individuals and the public purse.

9. It is very important that older people are not seen as a 'burden' on public services, nor the cause of many of the challenges that public services currently face. Older people are a significant asset, worth £1bn a year to the Welsh economy[15] and they have a rightful expectation of care and support at the time of their greatest need. Failing to sufficiently invest in the right kind of care will ultimately increase the long-term cost for public services. Whilst social care is a cost within public services, it is also important to see it as an investment in the social capital of Wales.

Creating Sustainable Health and Social Care Services in Wales

10. It has been clear for many years that the demographic changes taking place in Wales will have a significant impact upon the need for, and nature of, support from public services. However, changes were not made when the wider economic environment was more conducive to support the long-term change that was needed. We now have a range of challenges crystallising within public services at a time of huge economic uncertainty, both in relation to domestic austerity and the potential economic impact of Brexit.

11. This failure to effectively plan for the long-term has left the health and social care sectors in a position where they are required to meet increasing levels of demand, which is becoming increasingly complex, whilst radically redesigning their models of care. At the same time, they have had an increase in the duties placed upon them from a range of legislation without a significant increase in the resources available to them. The increase in pressure on the statutory sector has also meant that the third sector has had to contribute more towards preventative services and commissioned services within limited budgets.

12. Whilst the debate is frequently framed in the context of the challenges faced by public services and their longer-term sustainability, it is important not to forget the impact on the lives of older people. There are older people who are in hospital unnecessarily, who move into residential care earlier than they would have needed to and those who receive a level of care which barely meets their needs or are unable to access the services and support they need. This not only causes great distress but also exacerbates ill health and demand for support, creating a vicious cycle of enhanced need and dependency.

13. It is too early to judge the impact that the Social Services and Well-being (Wales) Act 2014 will have on the long-term sustainability of the social care sector. However, one of the key aspects will be the effectiveness of the Population Assessments in respect of planning for, and responding to, identified future demand. It is not yet clear

whether the data that underpins the recently published Population Assessments and the accompanying National Population Assessment report is sufficiently robust to provide an adequate assessment of how services will need to change to meet the needs of future generations.

14. In my view, there are a number of key areas which must be addressed to create more sustainable health and social services in Wales.

Investment in preventative services to reduce demand

15. Whilst it is clear that Wales has focused on the prevention agenda significantly in recent years, many older people still report that a crisis has to occur before they receive the help and support they need. Older people have told me that the help and support they need to prevent deterioration in their health is becoming increasingly difficult to access and it is clear to me that significant further investment is required in a range of preventative services.

16. Often the definition of 'preventative services' is too narrow and the vital role of wider community services, which are taking a significant financial hit, is not sufficiently recognised, in part due to the pressure on budgets in Local Authorities. Community services, such as transport, leisure and public toilets, significantly contribute towards maintaining older people's health, independence and wellbeing and help to prevent them accessing costly statutory services. Research has found that healthcare only accounts for 10% of a population's health.[16] It is therefore vital that further investment is made into other services that can positively impact on individuals' physical, mental and emotional health.

17. Furthermore, it is also clear that we are not investing enough in the third sector, which can be very flexible to local need and easily accessible, but it is increasingly being used to replace secondary support services, rather than focus on primary prevention.

18. There is now considerable debate about the need for individuals to take more responsibility for their own health. This is easily said by a system when it is in crisis, yet not so easily done. There is a clear

need to improve health literacy across Wales, recognised by the Parliamentary Review into Health and Social Care.[17] Wales also has long standing public health issues, which we have been slow to tackle or have ignored for too long, for example, drug and alcohol abuse in older people and a lack of long-term investment in services such as mental health, which undermine older people's abilities to make the right choice and take the right actions.

19. Whilst it can be difficult to significantly invest in these preventative models and services in the current financial settlement, it is clear that the future cost of not investing will be substantial. There must be a long-term vision that recognises there may be a considerable time lag before the benefits of containing demand for health and social care services will be felt but accepts the necessity of doing so to create a healthier population and more sustainable services.

Effective Workforce Management

20. Despite decades of workforce planning, the health and social care sectors are without sufficient numbers of staff with the right skills. This begs the question as to how effective Wales's longer-term workforce planning is across both health and social care.

21. At present, there are significant staff shortages within the social care sector; this applies particularly to domiciliary care staff but also specialist nursing staff within the care home sector.[18] Even if the money was available to drastically increase recruitment, there are not sufficient numbers of people with the right skills available. As a result of these staff shortages, people cannot be discharged from hospital and vulnerable people receive unacceptable levels of care.

22. Compounding this problem are the high turnover rates of staff in the social care sector, particularly within domiciliary care, estimated by the CQC to be at 28% annually,[19] and almost certainly higher within certain geographic areas of Wales. The reasons for this are multifactorial but include low pay, poor terms and conditions and the undervaluing of social care as a profession.[20]

23. Too often, vulnerable people are cared for by staff that don't have the necessary skills and competencies to ensure their quality of care

is at the standard it should be. I recognise the Welsh Government's intention to address this within the social care sector, through the registration of workers, but this will take a decade to take effect and does not address the variable skill base within the NHS.[21]

24. Whilst I welcome recent Welsh Government recruitment campaigns for GPs[22] and nurses,[23] more must be done to address the growing level of unfilled vacancies in the Welsh NHS.[24] As well as recruiting new staff, the Welsh NHS is finding it increasingly challenging to retain staff, due to issues around the cap on public sector pay, staff morale[25] and increased levels of sickness.[26] These factors have led to an increase in spending on costly agency staff to fill gaps, with Health Boards in Wales spending 60% more on agency staff in 2015/16 than in 2014/15.[27]

25. These are significant challenges in their own right and whilst there is uncertainty at present around post-Brexit Wales, it is clear that health and social care services have become more reliant on EU nationals in all parts of the workforce.[28] It is also likely that there will be increased competition across sectors and industries should the supply of labour reduce. Without an indication at the earliest opportunity about how restrictive the post-Brexit immigration system will be, both in relation to EU and non-EU nationals, our ability to effectively workforce plan will be further undermined. It is noted that the Migration Advisory Committee is not due to publish its recommendations until September 2018.[29]

Financial pressures

26. There has also been a sharp and significant increase in demand across health and social care, in part because of the increasing acuity levels of people requiring care and support and the complex nature of the support they require but exacerbated by a system that has struggled to release costs to focus on high impact, early interventions.

27. Cost pressures have also increased within the health and social care systems as a result of the introduction of the living wage[30] and staff shortages leading to the use of agency staff.[31]

28. In recent years, there has been an increasing focus on quality of care (including the impact it has), the redesign of services and securing a sufficient workforce base, both in terms of numbers and skills. This includes new regulation and inspection processes, staff ratios and training requirements, and more explicit quality criteria and outcomes. Whilst these are all essential developments, they do place cost pressures within the health and social care system.

29. The increase in care home costs for individuals has highly outpaced the growth in older people's incomes over the last five years, with the average annual costs of residential care in Wales standing at £30,940.[32] The ongoing cost pressure on an already fragile care home market must be addressed to avoid further destabilisation. There is also an emerging issue in the disparity of fees paid in the care home sector between Local Authority and self-funding residents. The higher costs charged to self-funders are in effect being used to cross-subsidise the costs of individuals placed by Local Authorities.[33]

Supporting Carers and Volunteers

30. There are at least 370,000 carers in Wales who care for their partners, neighbours and family members.[34] I have been clear that without our carers our public services would be bankrupt within weeks. Carers must be seen as an integral and valued part of the care system.[35] Investing in our carers is vital to reducing demand upon services, both in terms of the people cared for but also because of the significant health and mental impact on carers themselves.[36]

31. A study published in 2015 predicted that the number of people needing care would outstrip those 'available' to provide it by 2017.[37] Whilst other sources of support and developments in new technology will fill some of the gap, there will need to be an increase in the level of service provided by health and social care services.

32. Despite the difficulty and complexity of the work they do, many carers do not receive the level of support they need. The Social Services and Well-being (Wales) Act 2014 gives all carers the right to an assessment and consideration for a package of support but

many carers are not being offered an assessment and experience a 'postcode lottery' of receiving care and support.[38]

The importance of embedding an outcomes-based approach

33. The range of health and social care services provided to older people has always been extensive, but it is only over the past few years that Wales has moved to a clear focus on delivering outcomes. This is reflected in the outcomes indicators now in place for the Welsh NHS[39] and the national outcomes framework that sits behind the Social Services and Well-being (Wales) Act 2014.[40]

34. These, coupled with the stronger focus on integration and early intervention, should reduce the scope for unnecessary care and support in the future and reduce the need for longer-term and more expensive care.

Separation of health and social care

35. The historic structural separation of health and social care as distinct services no longer adequately reflects the reality of many older people's lives and nor does it reflect the growing focus on the integrated approach being taken by service providers, both at a strategic and operational level. Formal integration would incur significant costs and disruption to the system but there is clearly significant work underway to look at transactional ways in which greater integration can be achieved. This ranges from joint governance structures, through joint planning, to a growing number of integrated services, and more recently a growing focus on pooled budgets.

36. Further integration of health and social care services in this way, also involving housing, transport and the third sector, can help older people retain their independence and provide them with better care and support that meets their needs. Further integration must be made on the basis of improving the delivery of care and support, rather than restructuring health and social care organisations.

37. I support the Parliamentary Review of Health and Social Care's recommendation to create 'one seamless system for Wales' to break

down barriers between organisation to provide more integrated and person-centred care and support.[41]

A failure to share and roll out good practice

38. Over the past six years as Commissioner, I have seen and supported the development of a wide range of innovative services across Wales, often delivered at low cost but to significant impact for individuals. It is clear, however, that good practice does not travel well enough and this leads to missed opportunities to deliver better outcomes and reduce health and social care's overall cost. It is also clear that the role of the third sector is still not fully understood in developing these creative services, and is still not a full and equal partner in the strategic conversations and changes taking place. It is also clear that too narrow a focus of health and social care is taken and that other sectors, such as housing, are still not seen as an integral part of addressing some of the challenges facing health and social care.

The use of technology

39. One of the key areas where improvement is needed for the future is in the use of digital technology to assist in the delivery of health and social care services. Whilst there have been some advances made in Wales through the NHS Informatics Service, there have been delays in implementation[42] and progress has been patchy. There is a need for a more systematic and sustained approach that seeks to take full advantage of the benefits to individuals and the public purse.[43]

40. Introducing further digitalisation and use of technology into the health and social care system can help to improve service delivery, provide better outcomes for patients[44] and make more effective use of human and financial resources.[45]

41. Systems such as Artificial Intelligence (AI) can be used in a preventative way to help to predict which individuals or groups could be at risk of illness and enable the health and social care sectors to take action to prevent more costly health problems in the future.[46] AI could also help address the efficiency and funding gap that could

emerge in the health and social care sectors by automating tasks, triaging patients to the most appropriate services and allowing people to self-care and self-medicate.[47]

42. There has been a concerted effort to share patient data in Wales through the NHS Informatics Service, and in particular the Welsh Community Care Information System, which shares data between health and social care professionals.[48] Sharing data in this way and using AI-assisted diagnostics can provide better outcomes for individual patients, who will now only have to tell their story once, and avoid misdiagnosis and adverse incidents occurring.[49] Recent research by the BBC found that Health Boards in Wales are paying tens of millions of pounds each year in damages and legal fees for medical negligence; if some of this can be reduced by the sharing of patient data and assisted diagnostics, then the money can be freed up to be used to treat patients instead.[50]

43. I do recognise that there are challenges involved, not least in a financial sense, of integrating technology into the health and social care sectors. It has been recognised that digital change is often seen as slower in healthcare than in other sectors and that any changes would need to address cultural as well as operational issues.[51] There is also the challenge of convincing the public of the benefits of technology and AI in the delivery of health and social care, which currently does not have significant support.[52] There is also a risk that technology is seen as an easy, quick-fix and is used in a way that is not appropriate for the individual. Not all care and support can be provided with the assistance of technology but it will become an increasingly important tool going forward.

44. I welcome that the Parliamentary Review of Health and Social Care has recommended a series of actions that the Welsh Government should take to further incorporate technology into the delivery of health and social care and would urge the Committee to review how these recommendations can reduce funding pressures and improve outcomes for patients and service users.[53]

Funding Health and Social Care Services

45. From the above, it is clear that the health and social care systems face an unprecedented set of challenges, which are all crystalising at the same time. It is also clear that there is significant work already underway, albeit it should have been started a decade ago, at a national, regional and local level to transform the way that health and social care is provided, the impact it has and the quality that underpins the way in which it is delivered.

46. Much work has also been taken to reduce structural inefficiencies, although some still remain and are reflected in mechanisms, such as those that underpin Continuing Healthcare, poor workforce planning and insufficient investment in key preventative services. Whilst some of these issues are structural, a significant number are linked to the inability of health and social care to release costs upfront to invest in new models. It is not possible for me to specifically quantify the size of these structural inefficiencies, nor whether further action could be taken to release costs to invest in high impact areas.

47. However, I hold the view based on my work of the past six years, that there is a fundamental and underpinning issue that there is not a sufficient level of resources across the health and social care sectors to address all the issues identified above and there is an inadequate recognition that spending in other key sectors has a direct impact on older people's ability to stay healthy, active and independent. It is not always all about money but there comes a point when the overall level of funding does matter and does become directly correlated to the quality of care people receive.

48. The question of how to pay for care has occupied substantial political, policy and media activity over the past 20 years, yet still the issue has not been resolved and becomes more pressing every year. Core NHS spending now accounts for over half of the Welsh Government's total resource budget, compared to 39.1% in 2009/10.[54]

49. Despite proposals being put forward to tackle the issue of paying for social care,[55] there has been little progress at a national level, as the

Welsh Government insists it must wait to see the impact of consequentials derived from UK decisions before it can proceed. It must be questioned how long this position is sustainable.

50. It is clear that maintaining a sustainable health and social care sector, which meets increasing demand, will require significant additional resources in the years to come.[56] The NHS in Wales could be facing a ‘funding gap’ of about £700m by 2019-20, equivalent to 10% of its annual budget.[57] The Health Foundation has calculated that NHS spending in Wales needs to rise by 3.2% a year in real terms to keep pace with cost pressures. This spending increase can be met with a combination of increased funding and efficiency savings. However, since 1997 the NHS has achieved an average of 1% efficiency growth a year, meaning that the majority of budget growth would need to come from increased funding.[58]

51. The outlook for the social care sector in Wales is even more pressing, with a projected increase in cost pressures of 4.1% a year. If funding does not keep up with this increase in demand, many people will be left without the care and support that they need.[59]

52. The performance of the wider economy will be one of the most important influences on funding for the NHS and social care. The possible economic effects of the UK’s decision to leave the European Union are not yet clear.[60]

53. The British Medical Association have also looked at how the Barnett Formula affects the level of funding that the Welsh NHS receives and have calculated that the Welsh NHS could be underfunded by as much as £500m a year.[61] Whilst some of this may be compensated for in the Fiscal Framework negotiated by the Welsh and UK governments,[62] the Barnett Formula still remains based on relative population, rather than need.

54. If the future funding of health and social care cannot be guaranteed by economic growth, efficiency savings or further reform of the Barnett formula, then there must be a wider discussion about other ways to increase the available resources. There are different views around how this could be addressed but it is my view that the Welsh Government should consider using its newly acquired powers over

taxation to introduce a hypothecated levy that would support the health and social care systems.

55. The Welsh Government's proposals for a Social Care Tax should be explored in further detail and consideration given to the nature of the tax.[63] The approach taken by the UK Government to allow Local Authorities to introduce a 'social care levy' should not be adopted in Wales, as increases in council tax benefit more affluent Local Authorities, whereas the most deprived parts of Wales are in greater need as they have fewer people who can afford to pay for their own care.[64]

56. I would propose exploring the option of a hypothecated tax for health and social care, similar to the original purpose of National Insurance Contributions. Whilst there are drawbacks to hypothecation, including lower yields in times of recession when arguably the funds would be needed most, it does offer a way to increase the transparency of spending and make tax increase more palatable to the public.[65] The House of Lords Select Committee on the Long-term Sustainability of the NHS has provided a robust overview of the case for and against hypothecation.[66]

57. A health and social care tax should be closely correlated to clear and explicit outcomes and an expectation of quality that people can have of health and social care services. The approach should build on one of the founding principles of the NHS, which sees people pay in according to ability and take out according to need.[67] There is significantly strong support across Wales for a tax-funded NHS, which is free at the point of use and provides comprehensive care for all citizens.[68]

58. A case can be made with the public for an increase in their contribution through taxation to the health and social care sectors. Given the option between further reduced levels of care and increased taxation to fund the NHS, a survey in 2017 found that this would be supported by 64% of the public.[69]

59. Health and social care is funded in a variety of different ways across the world. A report to the Welsh Government by LE Wales on the future of paying for social care provides a detailed overview of the

systems of funding for social care in other UK nations, France, Germany, Sweden, Japan and Australia. Whilst there is some merit to looking at international examples, it is vital that the system adopted in Wales is bespoke to the needs of the people of Wales.[70]

Conclusion

60. It is clear that there are significant challenges facing health and social care services in Wales and without action the availability and quality of services will decline. The Welsh Government must heed the advice of the Parliamentary Review into Health and Social Care and bring forward a long-term plan for health and social care services.

61. As part of this process, there must be robust conversation about how to create a sustainable level of funding for these services, which includes the possibility of exploring a hypothecated levy.

62. I look forward to following the Committee's Inquiry and continuing to contribute towards the debate around the future of health and social care services in Wales.

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The Cost of Caring for an Ageing Population.

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Her views expressed are personal but based on her current focus which is the integration of housing into the health and social care agenda for older people in Wales.
Her comments are focussed on the terms of reference and the more qualitative issues which feed into the economics of care.

CONSULTATION COMMENTS - Terms of Reference bullet points are in italics.

1. *TOR overarching Aim: The purpose of the inquiry is to assess, in the context of the major economic and strategic challenges facing the Welsh Government in its development of policy, the financial impact of the cost of caring for an ageing population.*

The title disturbs me in the light of the current agenda for integration and use of the word “caring”. In light of the Strategy for Older People and Ageing surely the term should be ‘Caring and support’.

Also, it is very important to recognise and emphasise that the social care provided in Wales **includes** healthcare in the form of care home nursing (care home nurses have a statutory duty of care for health care which is a part of nursing care), and this also includes the personal care that may be provided by the delegated care support workers in care homes providing nursing. Nurses also have a duty to identify health care need from allied health professionals. The requirement for physiotherapy, occupational therapy, chiropody, dietetics, preventative dentistry as well as treatment, as equally available to care home residents as well as people living in their own homes is a known problem of equity and access – identified by the Older People Commissioner recently. Medical Care is provided by General Practitioners and this is also discussed in detail within several Older People Commissioner reports. All this needs to be included in the costing.

2. To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non- residential care, taking account of the role of informal carers who provide unpaid services to those requiring care;

a) If you define social care then this is all about the care provided for people to live well in their own environment. Social Care “concerns itself with helping people live their lives comfortably, particularly those people who require a certain degree of extra practical and physical help. Social care workers endeavour to provide this service of practical support with a view of helping individuals maintain their independence, to increase their quality of life and to help them lead fuller more enjoyable lives.”

b) So much of this “care and support” provided occurs in peoples’ own homes – some homes being provided by housing associations and private housing providers or indeed for older

people or people with specific needs requiring support for ordinary living skills in sheltered and extra care housing. It is crucial that RSLs are formal members of the Regional Partnership Boards Strategy group. This has been raised several times but is still not in place.

c) There is still a lack of understanding by, in particular, medical and nursing professions as to what can be provided in residential care – nursing and purely residential. Social Care Wales as the social care and social work regulator requires as mandatory that social workers in their qualifying degree learn about ageing and the life course whilst, for instance, registered nursing degree in Wales does not. This therefore has an effect on how nurses perceive care homes, cost and practice as well as ageing. Into this mix is the role of Community Nursing and how they support residential homes – this is a joint cost and must not be left out of the costing.

d) Now that there are RSLs building and managing care homes for residential care and nursing care it is important to understand the differentials for the shareholders in a private company with many homes and individual RSLs with one or two Care homes and a not for profit focus.

An example - Only recently the residential home where my father was living until 2015 was closed down in 2016. It was a registered charity with excellent Inspection Reports and a founder member and supporter of the My Home Life Cymru group of homes. It was one of the oldest residential homes in Wales – having been open for over 40 years. It closed down in 2016 because Torfaen and Newport Councils had their own approved providers and their own homes so needed to fill those places first. This denied choice for potential residents and also denied the fact this Charitable Home had flawless Reports whilst some of the Council Homes had significant regulatory omissions and poor reputations. NB This evidence can be found on CSIW website.

3. *To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts arising from the UK leaving the European Union;*

Whilst it is important the identify the real costs of providing social care this needs to reflect the full cost and full benefit. For example, there is still a large problem of Delayed Transfers of Care and Health Boards have just not moved fast enough to look at different models of care and support for rehabilitation and reablement. For instance, they have not used care homes and ExtraCare housing to develop a rehabilitation model. Wanless identified working in a different way and yet this is again repeated in the Parliamentary Review of Health and Social Care.

4. To consider the financial impact of current Welsh Government policies - including recent social services legislation and reforms to social care funding - on local authorities, care providers and service users;

See the example I provided in 2. I am encouraged by the work in my local Regional Partnership Board (of which I am a Citizen and Carer rep) on pooled budgets. This is a real opportunity to design a care home market that will benefit older people as much as it will benefit the funders of these services – in line with the policy agenda in Wales which focuses on the citizen and partnership. I would be encouraged by more not for profit and co-operative models of domiciliary and care home provision.

5. To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age;

See my comments above in terms of what is ‘social care”, integration and partnership models as well as value based care (see VBC in Aneurin Bevan UHB).

6. To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care. This will include the consideration of alternative models, including international examples, for the funding of social care to ensure a good quality, fair and sustainable service in a time of increasing demands on the health and social care systems;

I look forward to seeing how we can move further on by genuinely adopting a different way of care provision which is evidence and values based and based on the best practice we can find. It is nearly 20 years since I commented on the Royal Commission on Long Term Care and since then developments have not been planned well in advance, little real strategic direction, and been piecemeal. Having a Minimum Care Standards in the previous legislation which did not include anything on the “Quality” of care has meant the focus has been on buildings and process.

There is no Leadership from Welsh Government on Care Home Nursing – hence it is arguable that without some recent local nurse leaders care home nursing would still be without support and not evidence based – which is a statutory requirement for nurses. No guidance is issued for good practice nursing models (see Older People Commissioner latest report). It is also argued that because care home nursing is not valued within the nursing profession it cannot show its real cost to the benefit of older peoples’ health and well-being.

Finally, the Dilnot enquiry to which I contributed as a member of the National Partnership Forum for Older People was a great way to move forward on this and it was very disappointing about the lack of interest from Westminster government. This, I realise did affect how Welsh Government could respond positively so this planned work is very welcome.

7. *To consider the findings and conclusions of the Parliamentary Review.*

Please see my comment above about the involvement of Registered Social Landlords in the strategic development and planning from the Regional Partnership Boards. Also, that we must move quickly on this. Older People in Wales have benefited from some great action following the Strategy for Older People and let us continue with us through a clear and final action on a policy on the costs for care for an ageing population. We have delayed this for older people for far too long.

Lorraine Morgan – January 30th 2017.

Cardiff Council

Social Services

Response to the Inquiry into the Cost of Caring for an Aging Population

Brief Description of Organisation Submitting Information

1. This response is submitted by Cardiff Social Services. It reflects the views of Senior Managers in Adult Services Management Team, and includes the feedback from senior Finance Officers.

The Cardiff Context, Future Needs and Related Costs

2. The table below shows a rapid increase in the 65+ population of Cardiff during the 5 year period 2011-2016, with a total increase in 65+ population of 10.2% (4,854) over 5 years. During the same period, the number of people aged 65+ who Adult Services provided a service to rose by 6.1% (142), which was 4.1% slower than general population growth in Cardiff.

Year	2011	2012	2013	2014	2015	2016	5 Year Growth
Cardiff Population 65+	45,741	47,001	47,826	48,789	49,724	50,595	+4,854
Annual Population Growth (%)	-	2.75%	1.76%	2.01%	1.92%	1.75%	+10.2%

Service Users Aged 65+	2,304	2,337	2,427	2,485	2,456	2,446	+142
Annual Service User Growth (%)	-	1.43%	3.85%	2.39%	-1.17%	-0.41%	+6.1%

SU Growth vs Population Growth	-	-1.32%	2.10%	0.38%	-3.08%	-2.16%	

Service User % of Population	5.04%	4.97%	5.07%	5.09%	4.94%	4.83%	

3. The actual costs of providing commissioned services to Older People in Cardiff have risen from £21.3m in 2011/12 to £31.9m in 2015/16, a rise of almost 50% in just 4 years. The 2016/17 outturn indicated that the annual rise in market prices was as high as another 14.5%. This equates to an overall 71% rise in

the costs of delivering commissioned services to Older People (Aged 65+) in the 5 years since 2011/12.

4. Whilst the population growth has remained fairly steady over the past 5 years, ranging between 1.75% and 2.75% growth per annum, the number of service users aged 65+ Cardiff Council has been providing services to have been a bit more variable. For example, between 2012 and 2014 there were annual increases in the number of service users amounting to 7.67% over the period (1.4% in 2012, 3.9% in 2013 and 2.4% in 2014). However, in the following 2 year period (2015 and 2016) the number of service users aged 65+ receiving a service was actually reduced by 1.6% (-1.4% in 2015 and -0.4% in 2016), meaning the overall 5 year growth figure was brought back down to 6.1%. The fact that numbers of service users have been stabilised and actually decreased slightly since 2015 could be seen as an indication that the Council is limiting and managing demand more effectively at the front door since 2015 than it did previously, and this needs to be built upon in future years. The graph below shows this more visually.

5. It should be noted that all costs detailed in paragraphs 2-4 above reflect commissioning costs to the Council only. These costs do not reflect other pressures on Social Work budgets, e.g. staff costs. In addition, the below primarily considers the commissioning costs of Older People and those with Learning Disabilities which covers approximately 75-80% of Adults Services Budgets. No consideration is given in this review to other categories of Adults services expenditure such as mental health, physically disabled, substance misuse, emergency duty team and youth offending which cover the remaining 20% of costs to the service.

6. The analysis in paragraphs 2-5 above is based on statistics for the older people population who are aged 65+, but in reality, the core of financial expense is be incurred in the 85+ age range.The table below shows that the Cardiff 85+ population is steadily growing at approximately 2% per year (although 2013 is an exception with negative growth of 1.3%) since 2011 through to 2016, with the 85+ population growing from 6,926 in 2011 to 7,440 in 2016. These 85+

population growth rates are forecast to remain broadly similar to this in the medium term future, with anticipated population incereases of between 2% and 3% every year up until 2025, at which point Stats Wales forecast Cardiff will have a population of 9,257 citizens aged 85+.

Year	2011	2012	2013	2014	2015	2016	5 Year Growth
Cardiff Population 85+	6,926	7,085	6,993	7,135	7,293	7,440	+514
Annual Population Growth (%)	-	2.30%	-1.30%	2.03%	2.21%	2.01%	+7.3%
Service Users (SU) 85+	1,418	1,422	1,428	1,461	1,368	1,366	-52
Annual Service User Growth (%)	-	0.28%	0.42%	2.31%	-6.37%	-0.15%	-3.5%
SU Growth vs Population Growth	-	-2.01%	1.72%	0.28%	-8.58%	-2.16%	
Service User % of Population	20.47%	20.07%	20.42%	20.48%	18.76%	18.36%	

7. During the same 5 year period 2011 – 2016, the number of service users in Cardiff (aged 85+) has actually decreased from 1,418 in 2011 to 1,366 in 2016, a reduction of 52 service users (-3.5%). Given that the 85+ service user group is the where the core of financial expense can be incurred, this is a significant decrease in service users, especially when the number of 85+ citizens in Cardiff is actually growing substantially during the same period. We belive that this gives evidence of a strengthening front door in Cardiff.

The Role of Unpaid Carers

8. We are unable to capture the amount of care provided by unpaid carers because we do not have a comprehensive picure of all the unpaid carers in Cardiff who do not receive support from Social Services. However, we understand that the contribution that they make to meeting the care needs of the aging population in Cardiff is considerable.

9. We feel it is importnat to recognise that within this cohort, there will be some unpaid carers who are very overstretched in relation to their caring

responsibilities and there will be some who wish to care and are able to do this very comfortably without it having an adverse impact on their lives. Nevertheless, we are experiencing a growing cohort of older people in their 80s and 90s who are caring for their partners and / or older children who are in their 70s who are unlikely to be in a position to continue with their caring responsiblities for very much longer.

10. We also recognise that, unpaid carers within Cardiff's Minority Ethnic communities are fairly well hidden. They typically will not seek assessment or support form the Local Authority but are often caring for family members with very complex needs.

11. We are becoming increasingly aware that many unpaid carers who can't afford to continue to care are coming forward through the Direct Payment route. This not only impacts financially on the Local Authority in respect of an increase in the Direct Payment spend, but it also significatly changes the relationship that the carer has with the person they care for as a financial dimension to the caring role is introduced. Any government intiatives that are likely to make it more difficult for an upaid carer to continue to care, will have a knock on effect on the Local Authority spend.

People who Pay for Care

12. Social Services has access to around 40% of the residential / nursing beds in Cardiff. We know roughly how many self funders there are in the city based on research that was previously undertaken by the National Comissioning Board led by Steve Vaughan. However, we have no way of knowing when their funding will run out and when the Local Authority will be required to begin funding these arrangements. Additionallly, the funding cap is an issue and has put increased financial pressure on the system. Seperate feedback has already been provided by the Local Authority in relation to this finnaical pressure.

Capital limit increase

13. Despite additional funding of £4.5m included in the Welsh Government settlement to meet changes in the residential care capital threshold, we have identified this to be a financial pressure for next year and beyond as the capital limit rises in future years.

Financial Pressures on the System

14. We welcomed the Welsh Government Workforce Grant in the current year and this enabled us to begin to address with our providers the financial pressures arising that the implementation of the National Living Wage. We undertook a robust exercise that provided us with assurance from providers that they are paying the National Living Wage and adhering to other key workforce related matters that drive up quality and morale in the workplace.

15. However, whilst we are supportive of initiatives that drive up quality in the social care workforce and promote staff well-being and morale, we are aware that such initiatives lead to an upward price inflation to residential / nursing home rates, domiciliary care rates and supported living rates. This pressure will continue to increase over the medium term. Whilst the additional funding identified from Welsh Government will help, there is still likely to be a significant shortfall which will add to the uncertainty already being experienced across the market for social care provision. This will be balanced against increasing internal pressure within the Council to make further savings on the Social services budget allocation.

16. In the last 12 months, Cardiff has experienced an 8% increase in gross nursing bed price per week, after allowing for fee uplifts. This reflects general supply issues in the market plus increasing demand for beds from self-funders and public sector organisations. In cost terms, this pressure implies an additional annual impact of £1.2m in 2018/19, if current trends continue. In the longer term, different commissioning models and joint working are under consideration. These changes will seek to control prices and are expected to suppress (but not eradicate) this pressure, but it is considered unlikely that there will be a significant impact on the current trend in prices in 2018/19.

17. We are acutely aware that the majority of future savings are likely to come from service change and new ways of working, which are harder to achieve and require longer lead-in times. A lack of capacity to achieve such transformation changes that are needed, in the required time-frames, threatens the achievement of future savings unless an invest to save model is applied that supports the additional capacity required to drive these changes forward.

Capacity in the Market

18. Our current situation is a cause for concern because we do not have requests for care packages coming via the Hospitals of Community Re-ablement Teams. This is because cases are remaining in our internal Bridging Team. We are aware that this situation has the potential for de-stabilising the provider market. Whilst cases remain within our in-house Bridging Team we are reducing our external provider spend which is a higher cost. However, we cannot allow the flow out of hospitals and the Bridging Team to damage the market. We also have to carefully manage the flow because we do not want high numbers of people all requiring external resources at the same time. This is a tricky balance to achieve.

19. Over the last year we have noticed a decline in the need for general residential care, although in recent weeks this has increased slightly. We believe the decline in demand has been attributed to our “Home First” approach around prevention and delay, keeping people at home for longer. However, when needs escalate and it is no longer viable for an individual to remain at home, it is increasingly more likely that they will require nursing care rather than general residential.

20. Nevertheless, we are experiencing capacity in our nursing care beds and we have not experienced any challenges in appropriately placing people in need of Dementia Care. However, we acknowledge that the provider market continues to be very fragile and a series of factors such as National Living Wage, Sleeping In Judgement, pension changes, travel costs and impact of

HMRC changes will further increase costs in the future and could result in some providers being unable to sustain services in the long-term.

Recruitment & Retention

21. The recruitment of experienced Social Workers in Adult Services continues to be a challenge both in respect of permanent appointments and agency cover. This has led to gaps in the Social Worker workforce in Cardiff and consequently capacity issues have arisen.

22. We understand from our providers that they are experiencing significant difficulties recruiting and retaining quality Social Care Workers. The impact of Brexit is likely to exacerbate this situation. Likewise, whilst we recognise that the implementation of the Regulation and Inspection of Social Care (Wales) Act 2016 will drive up quality within the sector, we also recognise that providers are very anxious about its impact on recruitment and retention.

23. Earlier this year we launched a “Be a Care Worker” campaign in conjunction with local providers to raise the profile of careers in Social Care and to promote recruitment to the sector. This had limited success in terms of recruitment, but the campaign successfully celebrated the contribution that Social Care Workers make and therefore was an important factor in raising morale amongst staff already working in the sector. A celebratory event held in November 2017, hosted by our Regional Workforce Partnership in conjunction with Cardiff and Vale College, that recognised the achievements of Social Care staff who have gained a qualification also had a similar impact.

24. We recognise that more work needs to be done to integrate our Social Care workforce strategy with that of the University Health Board and this will be a priority for the Regional Workforce Partnership going forward. We also recognise the need to undertake more joint training across Social Care and Health, with programmes that support multi-disciplinary approaches. Our longer-term workforce planning will take account of the new approaches we

are seeking to implement and the changes will need to ensure we have a workforce with the necessary skill mix to work in a more integrated way.

Fiscal Levers Available to Welsh Government to Reform Arrangements for Funding Social Care.

25. The funding focus continues to be on Winter pressures, However, the way in which funding is streamed means that there is a continued focus on demand at the front door rather than intermediate or long-term care for citizens.

26. The way in with Health provide care with more community-based approaches rather than a reliance on hospitals and the disinvestment from the acute sector ultimately requires Social Services and Health to work more closely in an integrated way. However, we believe that decisions will have to be made at a national level regarding funding of acute services whilst the approach continues to change, moving more towards community services. We believe that double-funding will be necessary to successfully support this shift. However, in the past we have experienced Health closing wards in order to address financial pressures and the money has not followed the development of community services.

27. We believe that investment in preventative services must be the core priority for Welsh Government in line with the philosophy of both the Social Services and Well-being Act and the Wellbeing of Future Generations Act and in terms of sound budgetary policy. However we acknowledge that pressure on hospital services has never been greater and health organisations have therefore struggled to redirect resources into preventative services based in primary and community settings.

National Assembly for Wales Consultation:

The Cost of Caring for an Ageing Population

Submission by Wales Public Services 2025

January 2018

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Summary

The evidence set out in this paper primarily comes from our analysis of local government spending in Wales through the period of austerity (2009-10 to 2016-17)[1], including on social care for the over-65s. It therefore covers only one aspect of the costs of caring for an ageing population and there are several caveats:

- Gaps in the current published data for Wales mean that we have not been able to directly associate changes in social care spending to changes in the health and wellbeing of service users and carers. We cannot comment on the level of public spending required in order to reach a specific ‘quality’ of care services in future.

- For reasons we set out below, the data we draw on may not fully capture the developing, but patchy, trend towards more integrated working between local authorities and the NHS, for example through the Regional Partnership Boards, the use of Section 33 pooled budgets and the Integrated Care Fund.

- Our paper does not cover the complex issues surrounding demographic pressures on health spending. We note the comment from the Office for Budget Responsibility that ‘demographic effects have explained only a small part of the increase in health spending over past decades and they are likely to remain a relatively small, although growing, driver of spending in the future’. [2]

Patterns in demand for social care services for those of pension age:

- Net current spending on social services for over-65s by Welsh local authorities in 2016-17 was £ 565 million, about 10% of total net service spending. Although Welsh local authorities have broadly protected real terms spending on social services as a whole through the period of austerity, the pattern across client groups has varied. Whereas spending on looked after children rose substantially, net local authority expenditure on older adult (aged 65+) social care services declined slightly, by 0.8 per cent (£4.3m in 2017-18 prices), between 2009-10 and 2016-17. Given the rising population of over-65s, this was equivalent to a reduction of 14.4 per cent per older person.

[1] http://www.walespublicservices2025.org.uk/files/2017/11/Austerity-and-Local-Government.pdf

[2] http://cdn.obr.uk/FSR_Jan17.pdf

- This appears to have been accompanied by a more targeted approach to spending. The data points to a decline in the number of older adults supported by local authorities, despite a growing population. However, available data indicates the possibility of a significant (17%) increase in the level of spending per service user, which may reflect changes in local level eligibility criteria for support and a focus on individuals with relatively higher needs.

- The English Longitudinal Study of Aging (ELSA) provides one model in which the Welsh Government could invest so as to monitor how the health and wellbeing of pension age adults and those around them is effected by public policy.

Future social care needs and related costs

- The best available evidence on the future costs of providing adult social care in Wales[3] suggests that demand for adult care (that is, care services for all individuals aged 16 and over) should be rising by around 4.1% a year from 2015 up to 2030-31 due to demography, chronic conditions and rising costs.

- The general direction of this projection is supported by recently forecast trends in disability and life expectancy in England and Wales up to 2025.[4] According to this research, although total life expectancy at age 65 years will increase by 1·7 years up to 2025, life expectancy with disability will increase more in relative terms, with an increase of roughly 15% from 2015 (4·7 years) to 2025 (5·4 years) implying greater age-specific demand pressures on older adult care services.

- The rising number of over-65s mean that maintaining 2016-17 levels of local authority spending per adult aged 65+ on social care over the next decade would require an 18.0 per cent (£101m) real terms rise in net current expenditure by 2026-27, or a 27.2 per cent (£154m) rise by 2030-31. The Health Foundation demand projections would point to a much bigger real terms increase: 83% by 2030-31 (around £470 million).

[3] Watt and Roberts (2016), 'The path to sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31', available here: http://www.health.org.uk/sites/health/files/PathToSustainability_0.pdf

[4] Guzman-Castillo et al. (2017), 'Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study', Lancet Public Health, available here: http://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30091-9.pdf .

- However, these estimates only project what is required in order to maintain a specific supply of services based on a fixed starting position and policy mix, with arbitrary importance therefore placed on the chosen base year of analysis.

The fiscal levers available to the Welsh Government

- There may be limits to the extent to which Council Tax can be used to generate significant additional funding. Collected council tax (currently around £1.5 billion a year) increased by 20.6% in real terms between 2009-10 and 2016-17, partially offsetting reductions in Welsh Government funding for local government. A regressive tax as it currently operates, council tax now accounts for a higher proportion of average household disposable income in Wales than in 2009-10.

- Wales' devolved tax powers open up new financing options although the challenge remains substantial. A recent estimate indicated that changing the Welsh rate of income tax by 1p across each band could lead to an increase in the Welsh resource budget of around £200 million a year (subject to behavioural responses), although further research is taking place. Other factors such as change in UK fiscal policy or growth in the Welsh economy could have a significant impact. As things stand the use of devolved tax powers could be part of the solution but may not offer the whole solution.

- This suggests that further options need to be explored. Proposals for a funded contributory system of financing older adult care represent a promising alterative to the current pay-as-you-go model in that it could promote intergenerational fairness and value for money.

- The UK has some of the highest rates of 'intensive' informal caregiving in Europe (defined as 11+ hours of care per week), which is associated with lower levels of mental well-being. New data is required to evidence possible policy responses, from which future cost projections and fiscal lever options can be decided.

Introduction

The present submission to the National Assembly for Wales' consultation into the financial impact of the cost of caring for an ageing population will seek to address the following three items from within the inquiry's broader terms of reference:

1. To examine patterns in demand for social care services for those of pension age;
2. To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age; and
3. To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care.

One key limiting factor common across our response to each of these questions is the current deficit in published data from which to directly associate changes in social care spending with the health and wellbeing of service users and carers in Wales. As a result, we are not able specify a 'correct' amount of public expenditure in any given period, as defined by an objective and measurable metric of health and wellbeing outcomes for all adults of pension age, whether or not they receive formal local authority organised care support.

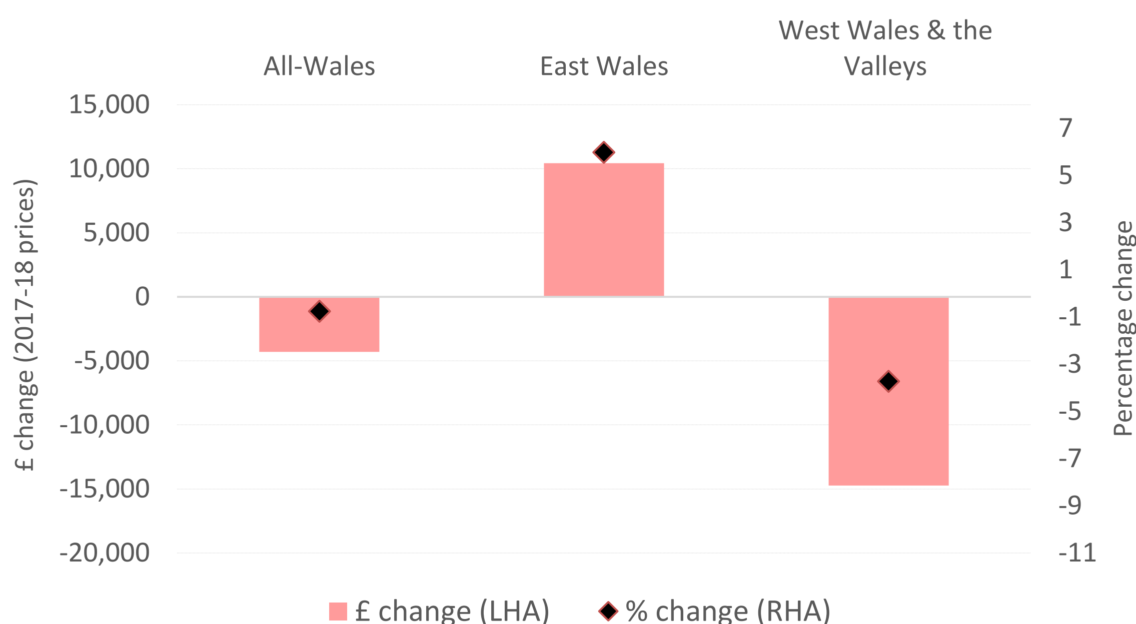
The recent Parliamentary Review of Health and Social Care in Wales has stressed the importance of developing a national health and social care data resource to drive decision making and improve health and care quality.[5] . As we discuss below, longitudinal data available in England offers one model in which the Welsh Government could choose to invest.

[5] See Annex C, Recommendation 7: Innovation, Technology and Infrastructure (http://gov.wales/docs/dhss/publications/180116reviewen.pdf)

1. Patterns in demand for social care services for those of pension age

Across Wales, total net public expenditure on older adult (aged 65+) social care services declined by 0.8 per cent (£4.3m in 2017-18 prices) between 2009-10 and 2016-17.[6] Figure 1 shows that this net decrease was led principally by regions in West Wales and the Valleys, where spending declined by 3.7% (14.7m). Nonetheless, the revenue outturn figures demonstrate a clear prioritisation of older adult social care services relative to most other local service areas (see Table 1). Indeed, between 2009-10 and 2016-17, older adult social care rose as a share of total local authority service expenditure by an average of 0.8 percentage points across Wales (1.1 ppts in East Wales; 0.7 ppts in West Wales and the Valleys).

Figure 1: Change in net current expenditure on older adult (aged ≥65) social care by region, 2009-10 to 2016-17 (2017-18 prices)



Source: Local government revenue outturn data (available here: https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue/Outturn/revenueoutturnexpenditure-by-authority)

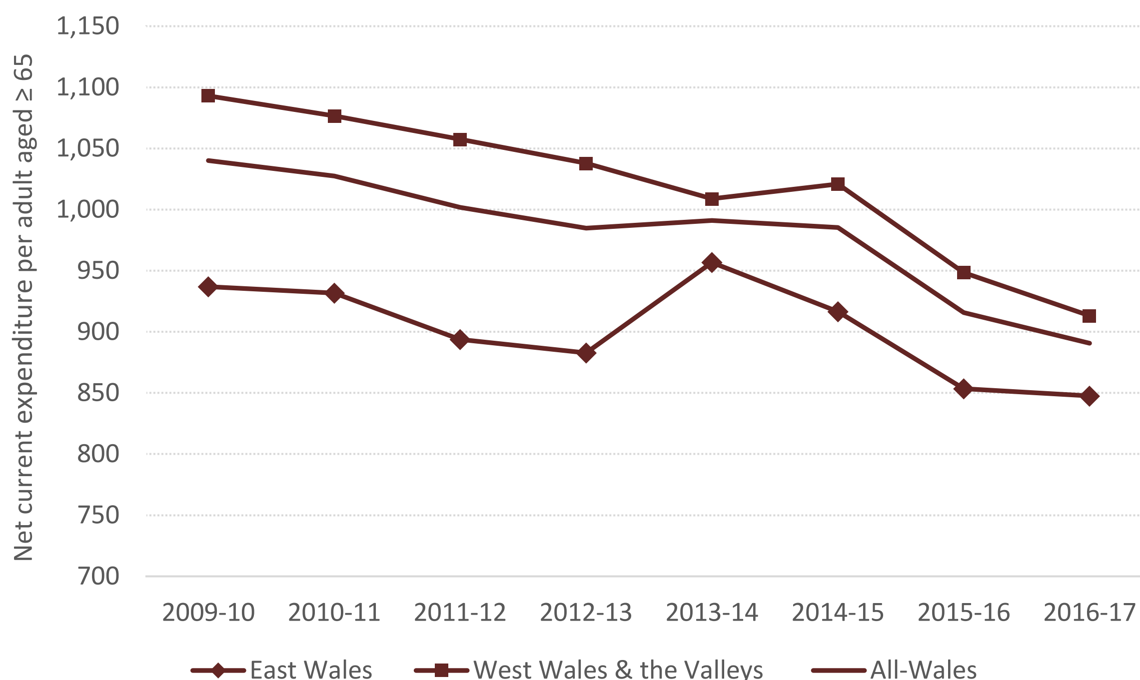
Given the trend in Wales' ageing population, this slight decline in total revenue spending meant that spending on a per head basis decreased by 14.4 per cent between 2009-10 and 2016-17, equivalent to £149 per adult aged 65 and over.[7] Regionally, this decline was more

[6] Note that all revenue outturn figures quoted here related to older adult social care reflect 2017-18 prices and have been adjusted to include separate funds pertaining to service strategy for all adult care services. In 2016-17 this came to £9.5m which we then divided proportionately between older and younger adult service spending.

[7] In 2009-10, adults aged 65+ made up 18.0 per cent) of Wales' population (547,597). By 2016-17, their share had risen to 20.4 per cent (635,659).

pronounced in West Wales and the Valleys (16.5%; £180 per head) compared to East Wales (9.5 %; £90 per head), although as can be seen from Figure 2, spending in the latter region remained below the former throughout the period. In nine local authorities spending per head declined by around a fifth or more.

Figure 2: Region specific trend in per capita (aged ≥65) expenditure on older adult social care, 2009-10 to 2016-17 (2017-18 prices)



Source: Local government revenue outturn data (available here: https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue/Outturn/revenueoutturnexpenditure-by-authority) and population estimates by local authority (available here: https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/Local-Authority).

That total spending on older adult services declined over the recent period may seem anomalous, particularly given the presumed demand pressures that accompany an ageing population. Between 2009-10 and 2016-17, the area that saw the most significant growth within local authorities' broader social care budgets was looked after children, which rose by 37 per cent (£72m) in real terms, reflecting a rise in the number of children requiring care support services annually (up 27% since 2009).[8] Linked to this, one explanation might be that service teams have switched focus over the recent period of austerity toward concentrating

[8] Data available from StatsWales: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-Looked-After.

support on a smaller number of relatively higher needs individuals given the statutory flexibility within which care eligibility is determined.

Both the new statutory framework brought about by the Social Services Well-being (Wales) Act 2014 (effective April 2016), as well as the previous regulations (NHS and Community Care Act 1990), afford councils a significant amount of discretion in determining whether an individual's care needs are eligible for local authority support (see the Annex). The implication is that councils are not bound to support all adults in all circumstances. This may in turn highlight the importance of informal networks.

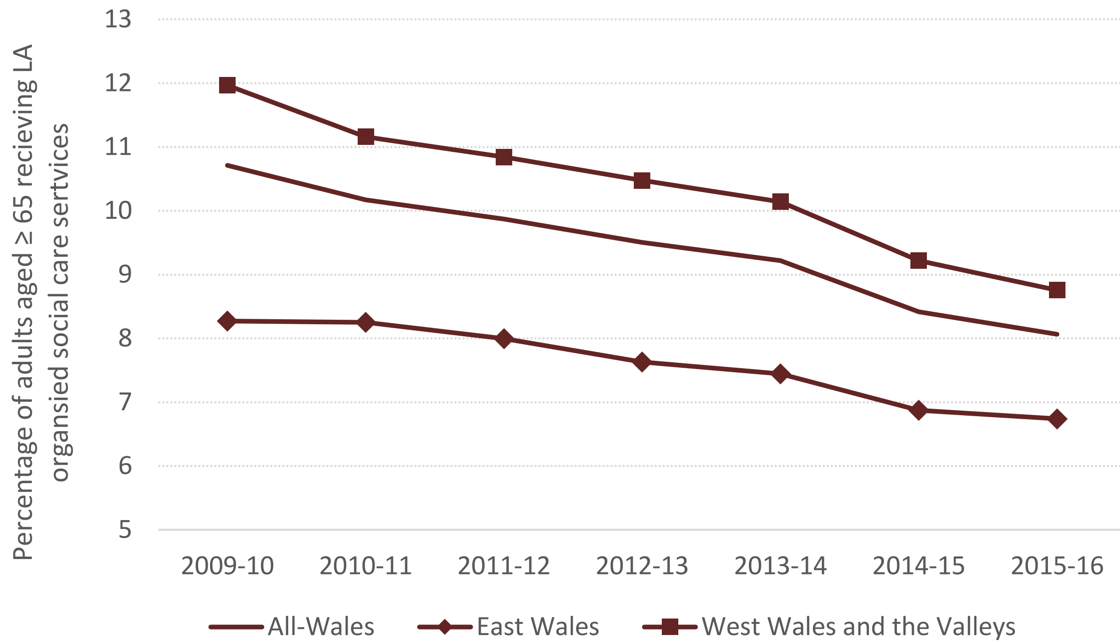
As a result of this flexibility, analysing both historic and future patterns of demand may be complicated by changes in what constitutes 'effective demand' (i.e. the number of pension age adults seeking local authority support that are also deemed eligible).

Data available for the period 2009-10 to 2015-16 shows that the total number of older adults supported by one or more kinds of local authority organised care services declined by 14.1 per cent, or 2.6 percentage points as proportion of the older adult population (Figure 3). One explanation may be a trend towards tightening local care package eligibility criteria. As a result, spending per service user apparently rose by 17.0 per cent across Wales (11.8% East Wales; 18.6% West Wales and the Valleys), equivalent to £1,646 per head (£1,336 East Wakes; £1,696 West Wales and Valleys) by 2015-16 (Figure 4).

However, newly available data showing service user frequencies produced for the first time using the computerised Welsh Community Care Information System (WCCIS) in 2016-17 does cast some doubt over the accuracy of previous years' reported figures, which appear to show a significant downward bias.[9] Whether or not older adult social care spending has become concentrated, it is apparent that predictions of increased service demand pressures resulting from Wales' rapidly aging population are not clearly reflected in the latest available local government revenue outturn figures.

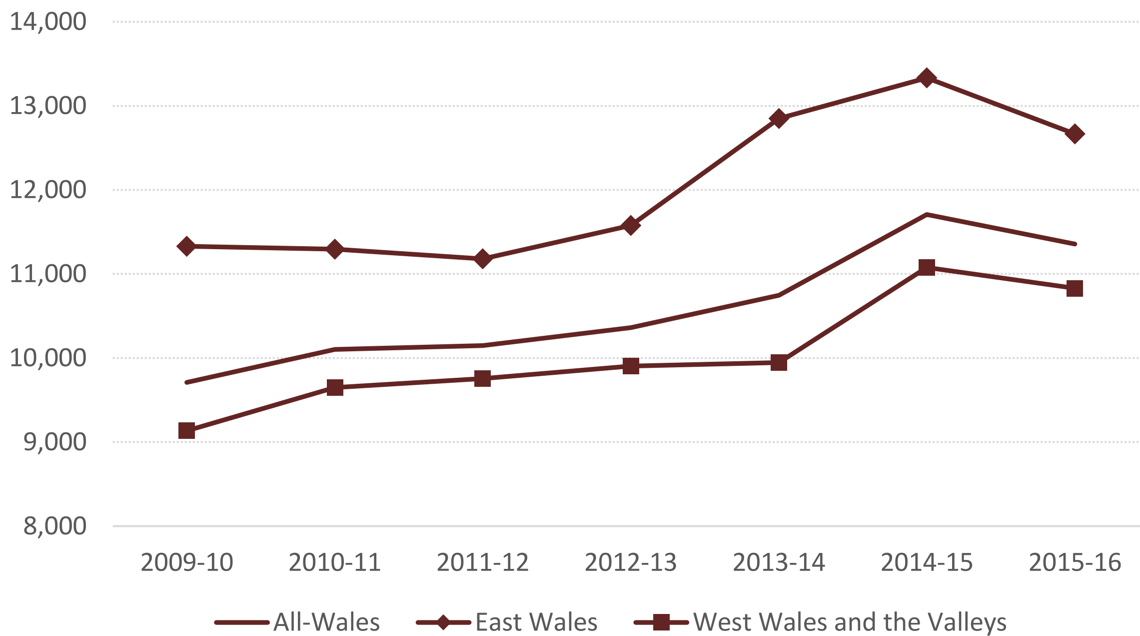
[9] The WCCIS service provision data shows that in 2016-17 there were 62,598 older adults recorded as receiving one or more forms of support; a figure which does not include figures for Merthyr Tydfil and Carmarthenshire which were unable to collate data (see source: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Adult-Services/Service-Provision/adultsreceivingservices-by-localauthority-clientcategory-agegroup). By contrast, previous year's figures show a steady decline in provision from 2009-10 (58,657) to 2015-16 (50,386). Although a sharp rise in provision between 2015-16 and 2016-17 is feasible, the shift in trend does suggest that data collected prior to the WCCIS system in April 2016 may be less accurate. However, so long as any downward bias remained consistent over the period 2009-10 to 2015-16, then the general pattern shown in Figure 4 would remain valid.

Figure 3: Region specific trend in adults aged ≥65 recorded as receiving LA organised social care support as a proportion of the total older adult population, 2009-10 to 2015-16



Source: Adults receiving services by client category (https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Adult-Services/Service-Provision/Prior-to-April-2016/adultsreceivingservices-by-localauthority-clientcategory-age)

Figure 4: Region specific trend in spending per adult aged ≥65 recorded as receiving social care support, 2009-10 to 2015-16



Source: Adults receiving services by client category (https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Adult-Services/Service-Provision/Prior-to-April-2016/adultsreceivingservices-by-localauthority-clientcategory-age)

We have not been able to analyse whether any changes to the way services were organised over the period 2009-10 to 2016-17 resulted in significant efficiencies without impact on service quality or to the well-being of those deemed ineligible for support. A recent report by the Royal College of Occupational Therapists showed that following a review into 227 care packages in the Cardiff area between April 2015 and March 2016, the council was able to save £395,279 due to individual care packages being right-sized to actually better meet service user needs.[10]

It is not clear whether spending of income from the Welsh Government's Integrated Care Fund (ICF) is ultimately recorded in local government revenue outturn figures. This may affect the trends observed.[11] However, if local authorities are indeed responding to heightened resource pressures by applying more restrictive eligibility criteria, the impact that this may be having on the health and well-being of those deemed ineligible will be very difficult to measure directly in Wales .

In England, the English Longitudinal Study of Aging (ELSA) – drawing on a representative cohort of over 10,000 men and women aged ≥50 years and funded by the UK Government, – contains information on the health status and support received by older people who report difficulty with various daily activities.

Investment by the Welsh Government into representative longitudinal data sources that can monitor the interaction between older people with varying degrees of life-limiting conditions and local public services could significantly improve the evidence base on which both current and future resource allocations are be made. Although the correctional National Survey for Wales[12] does contain a limited number of questions pertaining to social care services (specifically, the subjective rating of the quality of care received by service users and their carers), investment in longitudinal data that includes objective measures such as biomarker data[13] would allow policy makers to determine the specific patterns of support that appear to

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[10] http://3clw1r2j0esn1tg2ng3xziww.wpengine.netdna-cdn.com/wp-content/uploads/2017/07/ILSM-Phase-II-WELSH-ENGLISH.pdf

[11] NHS Wales Health Boards act as a lead organisation for the ICF and paid the full funds. If a local authority incurs a cost as part of activities associated to the aims of the fund – that is, supporting people to maintain their independence and remain in their own home – then the health board would pass the relevant funding on to the local authority which would appear as income from joint arrangements in the revenue outturn figures. However, we are not aware of any source which details how much of the ICF (£60m in 2017-18) is maintained by the Health Boards and is hence excluded form our analysis.

[12] http://gov.wales/statistics-and-research/national-survey/?tab=el_home&topic=nhs_social_care&lang=en

[13] Biomarkers have been defined as a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a therapeutic intervention. Examples include resting heart rate, grip strength and measures of inflammation such as C-reactive protein (CRP).

promote healthy ageing in the Welsh population at present, from which benchmark health and service delivery targets could be subsequently formed.

Table 1: Changes in older adult social care spending, 2009-10 to 2016-17 (2017-18 prices)

	LA spending (2017-18 prices)		**Percentage (*ppt*) change**
	2009-10	**2016-17**	
All-Wales			
Older adult (≥65) social care (£m)	569.6	565.3	- 0.8
Per capita (£)	1,040	891	-14.4
% of total service spending	*9.1*	*9.9*	*0.8*
East Wales			
Older adult (≥65) social care (£m)	174.2	184.6	6.0
Per capita (£)	937	848	-9.5
% of total service spending	*8.1*	*9.1*	*1.1*
West Wales and the Valleys			
Older adult (≥65) social care (£m)	395.4	380.6	-3.7
Per capita (£)	1,093	913	-16.5
% of total service spending	*9.7*	*10.4*	*0.7*

Source: Local government revenue outturn data (available here: https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue/Outturn/revenueoutturnexpenditure-by-authority) and population estimates by local authority (available here: https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/Local-Authority).

Summary:

- Net public expenditure on older adult (aged 65+) social care services declined by 0.8 per cent (£4.3m in 2017-18 prices) between 2009-10 and 2016-17, equivalent to 14.4 per cent per head.

- This appears to have been accompanied by a decline in the number of older adults supported by local authorities, which may indicate a tightening of local level eligibility criteria for support.

- The English Longitudinal Study of Aging (ELSA) provides one model in which the Welsh Government could invest so as to monitor how the health and wellbeing of pension age adults and those around them is effected by public policy.

2. Future social care needs and related costs

As we have noted in previous work,[14]the best available evidence on the future costs of providing adult social care in an aging Wales has been produced by the Health Foundation. This suggests that demand for adult care (that is, care services for all individuals aged 16 and over) should be rising by around 4.1 per cent a year from 2015 up to 2030-31 due to demography, chronic conditions and rising costs.[15] Total adult social care spending came to £1.14 billion in 2015-16 (2017-18 prices), meaning that a 4.1 per cent annual rise would see net public spending increase by 945 million (82.7%) by 2030-31. Applying this rate of change to older adult social care spending alone would see costs rise by £468.7 million.[16]

The general direction of the Health Foundation's projection is supported by recently forecast trends in disability and life expectancy in England and Wales up to 2025.[17] According to this research, although total life expectancy at age 65 years will increase by 1·7 years up to 2025, life expectancy with disability will increase more in relative terms. For this group, it forecasts an increase of roughly 15 per cent from 2015 (4·7 years) to 2025 (5·4 years) implying greater age-specific demand pressures on older adult care services. This would compound the fiscal pressures associated with an ageing population.

In previous work, we also showed that simply uprating older adult social care expenditure at the local government level by the expected growth in the adult population aged 65 and over would see expenditure rise by 24 per cent in 2020-21 relative to 2015-16 if spending per head on older adult social were returned to pre-austerity levels in 2009-10. If we take 2016-17 as our base year, maintaining this level of spending (£890 per older adult) over the next decade would require an 18.0 per cent (£101m) rise in net current expenditure by 2026-27, or a 27.2 per cent (£154m) rise by 2030-31.[18]

[14] Luchinskaya et al. (2017), 'A delicate balance? Health and Social Care spending in Wales', available here: http://www.walespublicservices2025.org.uk/files/2017/03/Wales-health-and-social-care-final_amended_04-2017.pdf.

[15] Watt and Roberts (2016), 'The path to sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31', available here: http://www.health.org.uk/sites/health/files/PathToSustainability_0.pdf.

[16] Author's calculation based on local government revenue outturn figures.

[17] Guzman-Castillo et al. (2017), 'Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study', Lancet Public Health, available here: http://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30091-9.pdf .

[18] Authors calculations based on 2016-17 local government revenue outturn data and 2014-based ONS population projections (available here: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/tablea15principalprojectionwalessummary).

These projections cannot tell us much about the level of public spending required in order to reach a specific 'quality' of care services or achieve specific public health outcomes in future. For example, the Health Foundation's projections were based on an updated version of the Personal Social Services Research Unit's (PSSRU) aggregate long-term care projections model adapted for the Welsh population's age structure. The approach taken involves simulating the impact on demand for care and support services of specified changes in demand drivers/cost pressures or specified changes in policy. This means that the projections reported in the Health Foundation's paper should be treated as indications of likely future expenditures on care and support if policies are left unchanged and drivers of demand follow the specified trends.

In effect, such estimates only project what is required in order to maintain a specific supply of services based on a fixed starting position, with arbitrary importance therefore placed on the chosen base year of analysis. As noted above, investment by the Welsh Government into a nationally representative longitudinal data source pertaining to pension age adults would enable researchers to investigate potential funding deficits now, which would thereafter facilitate a more 'outcome focussed' projection of costs in future periods.

Summary:

- The best available evidence on the future costs of providing adult social care in Wales suggests that demand for adult care (that is, care services for all individuals aged 16 and over) should be rising by around 4.1% a year from 2015 up to 2030-31 due to demography, chronic conditions and rising costs.

- Maintaining 2016-17 levels of spending per adult aged 65+ over the next decade would require an 18.0 per cent (£101m) rise in net current expenditure by 2026-27, or a 27.2 per cent (£154m) rise by 2030-31.

- However, these estimates only project what is required in order to maintain a specific supply of services based on a fixed starting position and policy mix, with arbitrary importance therefore placed on the chosen base year of analysis.

3. Fiscal levers available to the Welsh Government

Changes to the structure of council revenues since 2009-10 in Wales have reflected a significant rebalancing of how local government is funded, which has important implications for the long term funding of adult social care services.

Publicly funded local government services (otherwise known as net service spending or net current expenditure), including adult social care services, are financed via three principle streams of revenue: Welsh Government grants (the general revenue support grant, RSG, plus hypothecated specific and special grants earmarked for particular services), council tax and non-domestic rates (NDR).[19] Table 2 shows that between 2009-10 and 2016-17, an £805 million (16.2%) reduction in Welsh Government grant support to local government prompted a 20.6 per cent increase in total collected council tax revenues, equivalent to an additional £246 million.

Table 2: Local government revenues by source, 2009-10 to 2016-17 (2017-18 prices)

	LA spending (£m)		Percentage (*ppt*) change
	2009-10	**2016-17**	
All-Wales			
Welsh Government grants (ex. HB)*	4,975	4,170	-16.2
% of total revenues	*70.2*	*63.6*	*-6.6*
Council tax (collected)*	1,199	1,445	20.6
% of total revenues	*16.9*	*22.0*	*5.1*
NDR	913	943	3.3
% of total revenues	*12.9*	*14.4*	*1.5*
Total	7,087	6,558	-7.5

Note: *Council tax receipts are net of council tax benefit/reduction scheme which has been included within both the 2009-10 and 2016-17 Welsh Government grant figures.

Source: Financing of gross revenue expenditure (available here: https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue) and in-year council tax collection (available here: https://statswales.gov.wales/Catalogue/Local-Government/Finance/Council-Tax/Collection).

[19] All figures referring to Welsh Government grants exclude, for the purpose of this analysis, revenues accruing to Welsh unitary authorities in relation to housing benefit and housing benefit administration, which is sent directly to Welsh councils from DWP to match demand. Any additional sums spent by Welsh councils on housing benefit and housing benefit administration over and above the amount they receive from the UK government are included, although these figures are relatively negligible in size.

Council tax is widely regarded as structurally regressive between households,[20] and the Welsh Government has already committed itself to making council tax more progressive [21],possibly by changes to the banding structure. However, with further increases to the average Band D rate of around 4-5% expected across many councils in 2018-19,[22] alternative sources of revenue might be considered by the Welsh Government

The Wales Centre Public Policy are currently undertaking research looking at the implications of the new Welsh rates of income tax effective April 2019. Previous estimates have indicated that changing the Welsh rates of income tax by 1p across each band would lead to an increase in the Welsh overall resource budget of about £200 million (assuming no behavioural response),[23] although the Welsh Government has committed to maintain the current income tax rate for the duration of the current Assembly term (until May 2021).[24]

A prominent alternative solution to funding adult social care through piecemeal budgetary increments was recently outlined by Professor Gerald Holtham.[25] This would involve the creation of a funded contributory system for older people's care in order to mitigate demographic risk and give value to Welsh contributors through what would, in effect, be the creation of a sovereign wealth fund for Wales. This proposal has attracted much interest as an alternative to the current pay-as-you-go model of financing social care. Estimates as to the amount such a fund would need to release each year in order to meet demand will depend in part on the quality of cost projections.

The contribution from those providing informal care will be a key element in future resourcing of social care for over 65's. Recent research distinguishes between informal care giving and

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[20] Although low-income households will be exempt from paying council tax via the CTRS, council tax is regressive in the sense that you pay a lower percentage of property value the more valuable the property is, and there is an upper limit on payments. See IFS (2015), 'Little sense of direction in tax and benefit proposals', available here: https://www.ifs.org.uk/publications/7735.

[21] See p.13 of the Programme for Government (Take Wales Forward 2016-2021) document for this commitment, available here: http://gov.wales/about/programme-for-government/?lang=en.

[22] https://www.walesonline.co.uk/news/wales-news/how-much-every-authority-wales-13936534

[23] See Luchinskaya et al. (2017), 'Welsh Government Budgetary Trade-offs: Looking Forward to 2021-22', available here: http://www.walespublicservices2025.org.uk/files/2017/09/Looking-Forward-Report-Final-Updated.pdf

[24] Welsh Government. (2017a). Welsh rates of income tax FAQs. Retrieved from: http://gov.wales/docs/caecd/publications/171204-income-tax-faqs-en.pdf

[25] Holtham (2017), 'The promise of social care: Why Wales needs a community insurance fund and how to organise', available here: http://welsheconomicchallenge.com/wp-content/uploads/WNIfund-Proposal-Social-care.pdf

‘intensive’ informal care giving (defined as 11+ hours per week). It concludes that ‘intensive’ informal care giving is associated with lower levels of mental well-being, particularly among female ‘intensive’ caregivers on whom a disproportionate share of ‘intensive’ caregiving falls. The UK has been shown to rank 16th highest out of twenty European nations surveyed in terms of the prevalence of ‘intensive’ informal care giving, according data from the European Social Survey[26] (Round 7, collected 2014).[27]

This research found that countries with high overall numbers of informal caregivers tend to have lower numbers of intensive caregivers (for example, Nordic countries), which suggests that generous welfare states stimulate taking up a caring role, while at the same time taking away the necessity of intensive caring.

We suggest that any projection of the future resource needed to fund adult social care should take account of the pressures on those providing intensive informal care and the support they require. Again, such estimates would require the facility of new data able to capture the extent of informal care activity in Wales and its impact longitudinally on the health and well-being of care recipients and providers.

[26] The European Social Survey (Round 7) offers information on 37 623 respondents from 22 national random samples collected through face-to-face interviews. Complete information on the survey, including questionnaires, is available from http://www.europeansocialsurvey.org.

[27] Verbakel et al. (2017), ‘Informal care in Europe: findings from the European Social Survey (2014) special module on the social determinants of health’, European Journal of Public Health, available here: https://academic.oup.com/eurpub/article/27/suppl_1/90/3045950.

Summary:

- The UK has some of the highest rates of ‘intensive’ informal caregiving in Europe (defined as 11+ hours of care per week), which is associated with lower levels of mental well-being. New data is required to evidence possible policy responses, from which future cost projections and fiscal lever options can be decided.

- Meeting projected demand pressures on older adult social care services should consider the effects of raising the additional resource locally via council tax versus at the Welsh Government level through use of Wales’ new income tax powers.

- A funded contributory system of financing older adult care represents a promising alterative to the current pay-as-you-go model in that it promotes intergenerational fairness and value for money.

Annex A

Note on care assessments

Section 47(1) (b) of the 1990 Act placed a duty on local authorities to decide whether, following assessment, an adult's needs required a service to be provided, with any such determination made through reference to statutory guidance.[28] According to the guidance document (see paragraph 5.15), it was for individual local authorities to draw the line of eligibility according to their own local circumstances, albeit within a framework whereby eligibility is set at one of four bands: low, moderate, substantial or critical.[29] A similar discretion has been maintained by the implementing regulations of the 2014 Act (see the Care and Support (Eligibility) (Wales) Regulations 2015, regulations 3(a)-(d)). These regulations create what has been dubbed the '*can and can only'* criteria for eligibility, whereby an adult seeking care support is assessed to see if their needs can be sufficiently met by support coordinated by themselves, their family or carer, or by community-based services.[30]

While some commentators have noted that this criteria is conceptually flawed to the extent that it confuses 'eligible need' with access to support that may be leveraged in order to meet said need,[31] it is clear that councils will not be duty bound to provide support to adults in all instances given the complex calculus involved in the '*can and can only'* test, which appears to place emphasis on informal support networks.

[28] Creating a Unified and Fair System for Assessing and Managing Care – Welsh Assembly Government (2002), available here: http://www.wales.nhs.uk/sitesplus/documents/829/wag%20-%20creating%20a%20unified%20and%20fair%20system%20for%20assessing%20and%20managing%20care.pdf

[29] CSSIW (2010), 'National Review of Access and Eligibility in Adults' Social Care - Overview Report', available here: http://arolygiaethgofal.cymru/docs/cssiw/report/100927eligibilityen.pdf.

[30] http://www.communitycare.co.uk/2015/05/11/welsh-government-unveils-can-can-eligibility-test-social-care/
http://gov.wales/docs/phhs/consultation/141104Pt3and4execsummaryen.pdf

[31] Page 15.
https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0ahUKEwjIo5i86ILZAhVCLFAKHUlyDHIQFgg7MAM&url=http%3A%2F%2Fwww.lukeclements.co.uk%2Fwp-content%2Fuploads%2F2017%2F09%2FWales-SS-Well-being-Act-25.pdf&usg=AOvVaw17XHf6ZZE6_fGzEKCwvqyQ

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Wales Public Services 2025

The Wales Public Services 2025 Programme is investigating the long-term financial, demographic and demand pressures confronting public services in Wales and possible responses. Hosted by Cardiff Business School and independent, the Programme is a unique partnership between Cardiff University and five national bodies in Wales: the Welsh Local Government Association, SOLACE Wales, the Welsh NHS Confederation, the Wales Council for Voluntary Action and Community Housing Cymru.

Our goal is to create a civic space in which public servants, civil society, politicians and people across Wales can engage in open, informed, radical debate on how our public services need to change and what we need to do to get there.

Established in 2012, the Programme works with national bodies, research bodies and think tanks across the UK, including the Institute for Fiscal Studies, the Health Foundation, the Public Policy Institute for Wales, Wales Local Government Association, the Wales Audit Office and others.

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RESPONSE TO THE NATIONAL ASSEMBLY FOR WALES
FINANCE COMMITTEE
INQUIRY INTO THE COST OF CARING FOR AN AGING POPULATION

Who are we?

Care Forum Wales is the leading professional association for independent sector social care providers in Wales with over 450 members. Of particular relevance to this enquiry is the fact that our membership includes those who provide care homes and domiciliary care services for older people. Our members come from both the private and third sectors and we aim to engage and professionally support independent providers, to spread good practice, and help members provide a high quality service.

Our members include a variety of structures: large corporate groups, home-grown small and medium enterprises (SMEs), registered social landlords, and voluntary or charitable bodies.

Our members include organisations providing support to older people in a variety of ways:

- Residential care homes
- Nursing homes
- Domiciliary care providers, which provide social care to people in their own homes
- Extra care housing providers, offering varying levels of support facilities for tenants living in their own apartments.

The purpose of the inquiry is to assess, in the context of the major economic and strategic challenges facing the Welsh Government in its development of policy, the financial impact of the cost of caring for an ageing population

The Social Services and Wellbeing Act (Wales) gives an emphasis on early intervention and prevention and re-ablement, but we need to be realistic about the amount of paid-for care that will still be required. We need a system where we know what standards we expect and those are commissioned, paid for and inspected against. The public debate needs to move on from who inherits what when the older person who needs care is gone and instead discuss the standard of care they should receive, what it realistically costs and how we pay for that.

To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care

Our response focusses on the role of our members in providing paid for residential and non-residential care. That we are living longer is incontrovertible: Social Care Wales' National Population Assessment Report https://socialcare.wales/cms_assets/file-uploads/SCW-NPAR-ENG.PDF anticipates a 119% increase in those aged over 85 by 2035, and although healthy life expectancy is rising faster than life expectancy we can expect to see a growth in the number of people affected by dementia or physical frailty. Frailty can lead to increased falls, which can lead to increased dependence and lack of agility creating a vicious circle. Understandably, policy has emphasised keeping people independent and in their own homes as long as possible. However, it is clear there will always be those who need to enter a care home – and indeed as people become frailer, this can reduce the tendency to isolation and loneliness for some people.

Keeping people in their own homes for longer means providing not just more support but more complex support. Increasingly we are seeing domiciliary care workers needing to be trained to undertake some healthcare tasks. This extra training itself has a cost and in addition the nature of the tasks can also, for example, increase insurance premiums for providers. Additionally staff with increased skills and responsibility for higher level tasks will understandably expect some recognition of that in their own reward package. Some commissioners seem to find difficulty in recognising that they are not just commissioning a standard domiciliary care worker, but commissioning people to take on higher level tasks requiring more training and a greater taking of responsibility.

Similarly as we are able to keep people in their own homes for longer, those who do enter care homes are on average significantly frailer. This is leading to a requirement for both more and better trained staff in care homes, but this has not been sufficiently recognised in fees by public sector commissioners. It could be seen as a hidden efficiency saving over the ten to fifteen years and a significant factor in the pressure on providers and lack of sustainability of those relying on public sector fees.

To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts arising from the UK leaving the European Union

Providing care is a people intensive business. 60-70% of provider costs relate to staffing, with domiciliary care costs even more dependent on staffing costs than care homes where the building is also a significant proportion of the costs. Over recent years we have seen decisions of UK Government put a significant upward pressure on staffing costs with pensions auto-enrolment, changes to sickness pay and significant increases in the legal minimum wage. While all good social care providers recognise that in order to recruit and retain staff they need to offer terms and conditions above the legal minimum, the reality is that most public sector commissioners pay rates based on the assumption that staff will be paid at or near the legal minimum. It is an ongoing source of frustration for independent providers that local authorities and health boards will recruit staff they have trained because they offer them better terms and conditions than those same local authorities and health boards enable providers to pay through the fee levels they commission at.

The significant increases in the legal minimum wage mean that providers have had prioritise resources to keep up wages for the lowest paid staff, but this has had an effect of eroding differentials and making it harder to reward staff appropriately for taking on additional roles or undertaking training to improve their skills. Recruitment and retention is an issue in the sector for care workers, but also for nurses and managers. Providers are competing with supermarkets and the hospitality industry for care workers who can often earn more stacking shelves. We know that the NHS itself struggles to recruit nurses and it is even harder for independent providers who cannot match the benefits in terms of sick pay, maternity pay, pensions etc. Meanwhile there are not enough qualified social care managers to fill every vacancy in Wales and the requirement for managers from England to undertake additional qualifications is not helpful. The uncertainty around immigration status post-Brexit is already having an effect in terms of recruitment as many providers need to recruit from overseas to fill posts. When the income thresholds were introduced it became impossible to recruit care workers from outside the EU; it would be disastrous if the same were to happen with those from within the EU. But the uncertainty around immigration status going forward is already having an effect and putting potential recruits off. The difficulties in recruitment are leading to increasing numbers of providers needing to use agency staff, who come at a high cost, patchy reliability and in the worst cases can create concerns about safety. The sector also has difficulty recruiting sufficient welsh speakers to meet the needs of our elderly population, particularly outside areas with a significant welsh speaking population of working age. Welsh speakers are in high demand and can thus obtain terms and conditions over and above what most care providers are able to raise.

There are of course other pressures on costs too. For example, care homes have seen significant increases in food and fuel costs. The cost of borrowing for capital expenditure to build, equip and maintain care homes is also significant and we have seen fluctuations based on concerns about the riskiness and viability of the sector going forward.

To consider the financial impact of current Welsh Government policies - including recent social services legislation and reforms to social care funding - on local authorities, care providers and service users

In the previous section we have commented on the pressures and difficulties in recruiting and retaining an appropriate workforce. The regulations under the Regulation and Inspection of Social Care (Wales) Act will create a registered workforce. While we support this in principle, and want to see an increasingly professionalised workforce, we do have concerns that this will add pressure to the ability to recruit and retain the workforce needed on current terms and conditions. These measures will also create additional costs for the sector in terms of training, administration and registration fees.

The Regulation and Inspection of Social Care (Wales) Act also requires increased physical standards for new build care homes and extensions, with every room requiring an ensuite including a shower as well as increased space requirements. These will obviously increase the costs of any new additions to care home stock. In general we are only seeing new provision being built for the private payer market and it is likely under these requirements, without a change in public sector fees that this will continue. The recent Competition and Markets Authority report https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report which looked at care home provision across the UK was very clear "The current model of service provision cannot be sustained without additional public funding; the parts of the industry that supply primarily local authority (LA)-funded residents are unlikely to be sustainable at the current rates LAs pay. Significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs." It is not just the costs of borrowing per se that restrict new care home building, but the restricted proportion of a care homes costs that banks will lend, meaning that other money must be sourced from other sources, and restrictive covenants on areas such as profit, occupancy which can be punitive even for an outwardly successful enterprise. It may be that the recognition of the sector as a sector of national strategic importance may open up borrowing opportunities to help.

The Welsh Government has also taken decisions to cap the domiciliary care costs paid by an individual and increase the capital limit which is retained by those in care homes. While understandable and attractive to individuals and families, both these policies have taken money out of the care system which has not been replaced.

To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age

While there are savings to be made and duplications that could be removed from the system the likelihood is that the projected population increase will lead to increased needs and increased requirements for paid-for care. We must be ambitious about what standards we want for that care but also realistic about what it will cost. Providers are adept are providing what is requested and paid for but frustrated by an increasing and understandable pressure to improve standards without the means to fund doing so.

To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care. This will include the consideration of alternative models, including international examples, for the funding of social care to ensure a good quality, fair and sustainable service in a time of increasing demands on the health and social care systems

We welcome the consideration of a social care levy by Welsh Government as part of the consideration of tax varying powers. We would caution that it is important not just to decide how to raise money, but also what it is spent on. Merely increasing, for example, the capital limit retainable by those in care homes, would not inject more much-needed resources into the sector to, for example, recognise the increased professionalisation of staff and improve their terms and conditions accordingly.

As a society we need to decide what we want from care, commission it, pay for it and inspect it. We think it would be a step forward and assist transparency and understanding for the public if the Care Inspectorate Wales (CIW) were to include value for money reporting in their inspection reports as Estyn do for education settings. This would enable greater public understanding of the true costs of care and what could and should be provided at what price.

Fees are of course a difficult issue for commissioners. In many areas local authorities are in a monopsony position: they are by far the biggest buyer of care services with a small market of private self-funders and some NHS commissioned continuing healthcare. In such a market there needs to be an intervention to ensure fair fees are set: fair to both providers and tax

payers. There is ongoing work by Welsh Government in this area under its Care Homes Steering Group. We would endorse the recommendations of the Competition and Markets Authority report there is greater assurance at national level about future funding levels, by establishing evidence-based funding principles, in order to provide confidence to investors. We believe there needs to be a level of national oversight and review in order to ensure a system where commissioners are not simply focussed on the lowest costs, but actually consider strategically what they want to commission at what cost and that new cost burdens are managed appropriately. For example, we believe commissioners should consider whether and over what timescale they wish to move to all qualified staff in the sector being paid at least the real living wage. These strategic decisions should be built into the fee-setting methodology.

It is also vital that a settlement is reached with providers following the Supreme Court case on Funded Nursing Care http://www.bbc.co.uk/news/uk-wales-politics-40802237 which at the time of writing has still not been resolved, meaning providers have been subsidising a significant shortfall of funding while local authorities and health boards have disagreed about who should pay it. We also need to resolve the anomaly in some parts of Wales, where when an individual's needs increase to the extent that they move from Funded Nursing Care to Continuing Healthcare the fee paid to cover meeting their needs remains the same or in some cases goes down.

To consider the findings and conclusions of the Parliamentary Review.

We welcome the Parliamentary Review and its emphasis on a seamless service for the citizen and recognition that that should include independent providers. In particular we support the added focus on the workforce, which recognises long term recruitment issues and improving training, support and capacity to innovate for staff. This again needs to include those working in the independent sector with a focus on rewarding appropriately to recruit and retain.

It is of course the case that the remit of the Parliamentary Review specifically excluded funding, but this will need to be addressed as part of its implementation.

Consultation Response

The Cost of Caring for an Ageing Population

Finance Committee

January 2018

Introduction

Age Cymru is the leading national charity working to improve the lives of all older people in Wales. We believe that older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

We welcome the opportunity to respond to the Finance Committee's Inquiry into the Cost of Caring for an Ageing Population.

We would like to make the following comments in relation to the terms of reference cited for the Inquiry:

To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care;

1. By 2019, the population of Wales aged 65-84 years is expected to rise by 27% and the population aged 85+ years, by 127%[1].

2. In Wales, healthy life expectancies are increasing, but the number of years spent living with poor health is also increasing[2]. Public Health Wales states that men and women are likely to spend on average 17 and 20 years respectively living in poor health. Worryingly, differences in both life expectancy and healthy life expectancy between different areas in Wales are not reducing. In fact, men and women in the most deprived areas of Wales

[1] Public Health Wales Observatory (2018) Health and its determinants in Wales.
[2] Public Health Wales Observatory (2018) Health and its determinants in Wales.

spend approximately 19 and 18 years less in good health respectively, and die on average 9 and 7 years earlier respectively, than those living in the least deprived areas[3].

3. The instance of diseases people in Wales are living with is changing. Although the number of disability adjusted life years (DALYs) due to cardiovascular disease has fallen by 42% over the last 26 years, there has been a rise of 25% in DALYs associated with neurological conditions including dementia. 45% of adults aged over 75 in Wales report having two or more long term illnesses.

4. Wales Public Services 2025 states that local authority spending on social care for older people is not keeping up with population growth. It estimates that spending may need a 2.5% year-on-year increase until 2021 to return to the per head spend in 2009 - 10[4]. Although spending on local authority adult social care since 2009 has remained static in Wales, the growing number of older people means that spending per older person has actually fallen by over 12%.[5]

5. The statistics cited above indicate that demand for residential and non residential care will undoubtedly increase. Social care has historically suffered as a consequence of under-funding and this situation has been further aggravated in recent years as a result of widespread reductions in public sector budgets. The continued provision of good quality social care is unsustainable without a significant investment of funding to address the issue of persistent under-investment.

6. Although it is clear that caring for Wales' ageing population will require significant investment, the cost of not caring could be much higher. A failure to invest in services that keep people safe and healthier for longer will undoubtedly increase pressure on emergencies services, already struggling to cope with demand. (More than 82,500 people went to A&E in the month of November 2017, an increase of just over 2,660 compared to November 2016[6]).

7. In order to maintain the cost of caring at a manageable level, the Welsh Government must ensure that older people in every part of Wales can access effective hospital discharge programmes, support for carers and locally managed preventative services that are agile and responsive to need.

3

4 Wales Public Services 25 (2017) A delicate balance? Health and Social Care Funding in Wales.

5 Wales Public Services 25 (2017) A delicate balance? Health and Social Care Funding in Wales.

6 NHS Confed (2017) Available @ http://www.nhsconfed.org/news/2017/12/numbers-of-people-attending-accident-and-emergency-in-wales-are-up

8. **Informal carers**
The increase in the number of years people spend in poor health will inevitably place additional pressures on unpaid carers. According to recent figures there are more than 370 000 carers[7] living in Wales, representing 12.1% of the Welsh population. It is estimated that unpaid carers save the economy £8.1billion a year[8].

9. Too often in these financially difficult times, carers are increasingly relied upon to fill gaps in provision. As eligibility criteria has tightened year on year, fewer and fewer people are eligible for state-provided social care. Sadly, many carers and those they care for do not receive help until they are at crisis point. By this stage, not only are the health – physical and mental – and the financial future of the carer deeply compromised, but the required intervention is significantly more costly and intensive than preventive measures implemented at an earlier point. Carers play a vital role, both economically and socially. The health and social care systems simply could not cope without them. Reliance on carers is not a sustainable basis for meeting growing demand. Without adequate support for carers, pressures on the NHS and the social care system can only continue to grow.

10. Age Cymru believes that the Welsh Government must make greater provision for older carers across Wales in order to ensure they achieve an acceptable quality of life, in terms of mental and physical health and wellbeing, and opportunities for social and financial inclusion.

To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts arising from the UK leaving the European Union

11. Commissioning practices are fundamental to ensuring good quality social care is provided. One area in which difficulties have been evident in recent years has been with the practice of task and time based commissioning.

12. Commissioning needs to shift to an outcomes-based approach, reflecting the intention of the Social Services and Well-being Act. Purchasing care in units of time, or simply according to cost, makes it increasingly difficult for staff to delivery good quality care and preserve the dignity of the person being supported.

[7] Carers Trust (2018) Wales Available @ https://carers.org/country/carers-trust-wales-cymru
[8] Carers Trust (2018) Wales Available @ https://carers.org/country/carers-trust-wales-cymru

13. The price paid to the service provider by the local authority also has implications for the terms and conditions of those employed in the sector, and can impact upon recruitment, retention and staff morale. Social care is a sector in which zero hours contracts and the minimum wage are widespread. As a consequence, recruitment and retention of staff are both difficult, undermining the ability to provide good quality care. There are also implications for the ability to provide continuity of care. This is especially problematic in light of the fact that a growing number of those receiving support are living with dementia. Providing appropriate care to people with dementia requires continuity in terms of the staff providing care, as unfamiliar faces can lead to confusion, fear and even an exacerbation of difficult behaviour.

14. It is clear that the commissioning process needs to be led by people who have knowledge about, and experience of, the personal care services that they are commissioning. Without appropriate knowledge, there is a continued risk that the level and type of service commissioned are unsuitable to provide the necessary support to those on whose behalf they are being commissioned.

15. Domiciliary care services face a number of challenges if they are to provide a high quality service to the vulnerable older people of Wales. The care they provide is not ‘basic’, which suggests low-level, but rather ‘fundamental’ – essential to an older person living a more independent life and maintaining their dignity. The relationship between quality and dignity is critical – it is not just about what support is provided, but about the way in which it is provided. We have high expectations of our domiciliary care workers, which are not reflected in the way in which the role is viewed in broader terms. It is a difficult job yet society does not always appear to value the contribution these essential workers make in providing care for the vulnerable.

16. Conducting difficult work for low pay creates problems in recruitment and retention. Indeed, it is a testament to the dedication of many domiciliary care workers that they continue to do their job. Low pay, in combination with the perceived low social status of the role, is off-putting for many. This problem will only exacerbate the difficulty of delivering quality care as demand grows.

17. A high turnover within the work force is viewed as a significant factor exacerbating threats to the human rights of older people. Many of the issues that make it difficult to recruit domiciliary care workers also make it difficult to retain domiciliary care workers, especially when the difficulty of the role is not adequately compensated in comparison with jobs in other sectors that appear to be easier and which receive equal or higher levels of pay.

18. A core element of both recruiting and retaining domiciliary care workers is to

improve the terms and conditions relating to the role, to make the job both more attractive and also more competitive with the terms and conditions offered in other sectors to which staff could be lost, for example retail.

19. However, it is not clear that terms and conditions can be improved sufficiently to make the role more attractive to people without tackling the difficulties relating to commissioning processes and sustainable funding that must underpin improvement in those terms and conditions and provide sufficient rewards and incentives for undertaking a challenging role.

To consider the financial impact of current Welsh Government policies - including recent social services legislation and reforms to social care funding - on local authorities, care providers and service users; (section from Crisis in Care.)

20. Paying for care

Regulations derived from the Social Services and Well-being Act aim to introduce a single framework for both residential and non-residential care with regard to financial assessment and charging. However, there is a fundamental debate over the basic fairness of charging people for the care and support they have been assessed as needing. Age Cymru's longstanding view is that a far more equitable system would be to ensure that care services are provided free at the point of use in the same way as NHS services. This would ensure that care is available to everyone at their time of need and spread the cost of care services across the population, instead of the cost simply falling on those people unfortunate to develop care needs.

21. Currently in Wales there is a maximum weekly charge for non-residential care, which increased from £60 to £70 per week in April 2017. This policy represented a clear step forward in seeking to make non-residential care services affordable and eliminating large amounts of regional inconsistency in charging levels and practices. Paying for residential care in later life is a cause of concern for many older people wishing to pass on a financial legacy to the next generation. Consequently, Age Cymru recognises that the proposed increase to the capital limit will be welcomed by many. Although the local government financial settlement provided £4.5m to fund the commitment of increasing the capital limit used by local authorities that charge for residential care, our key concern is to ensure that the social care system is funded to meet the needs of our ageing population.

22. **Eligibility criteria**

Age Cymru has concerns about how the eligibility criteria contained within the Social Services and Well-being Act is being implemented by local authorities. The new criteria states that people are only eligible for care and support if their needs 'can and can only' be met by social services. However we have

heard from older people who feel that the assessors have made unreasonable assumptions about their ability to cope without formal support.

23. For example, Mrs G's husband was discharged from hospital with advanced dementia but no care assessment was carried out. Unable to cope without night time support, Mrs G arranged for a private care service to assist her husband for several nights per week. The bill for this support was over £2000 a month. When Mr G was finally assessed, the care plan did note the need for night time care, but did not treat this as a responsibility of the local authority as it was judged that the family had managed to cover these requirements themselves. The expense of this privately arranged care meant that Mrs G tried to carry out as much of the care responsibility as she could manage, a situation she found very difficult. (See appendix 1 for case study).

24. Mrs G's lack of formal support and respite had a very negative impact on her health and well-being and she confessed to feeling lonely and desperate. Our concern, illustrated by this case, is that unreasonable assessments made by local authorities about the level of support needed, are pushing more and more individuals and carers to crisis point, ultimately costing the NHS more. The aim of the eligibility criteria is to increase access to and use of locally based preventative services, but we fear that it is actually being used as a means to deny much needed formal support.

25. Residential care 'top up' charges

People entering residential care should have choice over their accommodation. In reality, choice is often limited, particularly in rural areas. Older people can be placed in a situation where there are no places available within a close proximity of where they or their family members live at a rate that their local authority is willing to pay. This can result in people being faced with little actual choice, and having to arrange third-party top-up payments in order to stay living locally or moving to an unfamiliar location that may be far away from friends and family.

26. Although the Social Services and Well-being Act's Code of Practice[9] requires authorities to assess an individual's and their relatives' ability to pay prior to placing a person in a home requiring third party payments, it is nevertheless found that relatives can be issued with unexpected bills. Age Cymru has been informed that even relatives in receipt of welfare benefits have been asked to contribute to their relative's care costs. It appears that in some cases, local authorities are failing to explain the requirement for relatives to pay top ups

[9] Social Services and Well-being (Wales) Act 2014: Part 4 and 5 Code of Practice (Charging and Financial Assessment), Welsh Government (version 2 – April 2017)

and are simply passing the additional payment requirements to relatives without their prior agreement or knowledge. (See appendix 2).

To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age;

and

To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care. This will include the consideration of alternative models, including international examples, for the funding of social care to ensure a good quality, fair and sustainable service in a time of increasing demands on the health and social care systems;

27. The Institute of Welsh Affairs has predicted that the number of people aged 65 and over receiving residential care services would increase by 82% between 2015 and 2035, and the numbers receiving community based services by 67%. However the Welsh Government's *Assessments and Social Services for Adults in Wales, 2015-16* shows that;
    - the provision of adult community-based care services is falling year on year
    - the provision of home care is falling year on year and
    - the provision of respite care is also falling.

28. Age UK has drafted these principles for reform which Age Cymru supports:

- A guarantee of sufficient quality and quantity of care for low income older people
- New financial products to meet the remaining costs of care for middle to high income older people, such as private insurance
- Payments to support the additional costs of disability continue to be available on a non means-tested basis as a national, legal entitlement
- Adequate funding for advice, assessment and support to arrange services
- An end to age discrimination in the provision of care and support
- A system which supports rather than penalises families and carers
- Alignment with the NHS and other local government services such as housing support
- A flexible system which gives users control and permits different types of care services, such as advocacy, to develop.

29. Reform cannot be achieved without a large investment of new money.

If we merely maintain the current funding level, the projected rise in older people living with complex needs means that we will cause misery and danger for hundreds of thousands of frail older people.

30. The Health Foundation found that adult social care funding in Wales as a whole (i.e. younger adults as well as older) would need to rise by 4% each year to a near doubling by 2030 and pushing spending up to £2.3 billion. Wales Public Services 2025, also found that local authority spending per older person has declined over the last seven years by around 13% and that £134 million a year more would be needed by 2020-21 to get back to 2009-10 per-capita levels[10].

To consider the findings and conclusions of the Parliamentary Review

31. Age Cymru welcomed the Parliamentary Review of Health and Social Care and its finding that too much care is reactive. Although we have stated earlier in this response that local authorities seem to be struggling to implement the Social Services and Well-being Act, adherence to the legislation which promotes preventative services should prevent families and individuals from reaching crisis point and save money in the long term.

32. We therefore support the Review's recommendation that '*care should be organised around the individual and their family as close to home as possible, be preventative with easy access and of high quality…….delivering what users and the wider public say really matters to them*.'

33. We also fully support the vision of a '*one seamless system for all*.' In our response to the Parliamentary Review, Age Cymru recommended that this could be achieved by the following steps;

   - Regional partnership boards must identify areas where pooled budgets and joint commissioning can be effective by increasing the focus on the provision of person-centred care.
   - The Welsh Government, local authorities and other funders must work together and with third sector organisations, to ensure that the preventative services they provide are maintained on a sustainable footing.
   - Where successful pilot programmes have been implemented, local authorities, local health boards and NHS Trusts should ensure the good practice developed is identified and shared across Wales.

[10] Wales Public Services 2015 (2017) A delicate balance? Health and social care spending in Wales.

- Local authorities and local health boards should develop effective mechanisms for the sharing of information and data.
- Older people need to be at the centre of all decisions and developments that impact upon their health and well-being including the social care that they receive.

Appendix 1

Case study regarding eligibility criteria

Mr G is in his 80s, has dementia, severe mobility difficulties and is heavily reliant upon his wife for personal care throughout the day and night. When Mr G was discharged following a lengthy period in hospital, Mrs G (also in her 80s) was told her husband would require two night time carers, as well as daytime care provision.

Although Mr G was assigned a social worker for a short period after discharge, a care needs assessment was not carried out for over 8 months. The couple were not provided with the resulting care plan for over 6 months and although the local authority claimed a financial assessment had been carried out, it was never located.

Unable to cope without night time support, Mrs G arranged for a private care service to assist her husband for several nights per week. The bill for this support was over £2000 a month. When Mr G was finally assessed, the care plan did note the need for night time care, but did not treat this as a responsibility of the local authority as it was judged that the family had managed to cover these requirements themselves.

The expense of this privately arranged care meant that Mrs G tried to carry out as much of the care responsibility as she could manage, a situation she found very difficult. Despite this, the authority did not assess her needs as a carer until Age Cymru's intervention, whereupon social services arranged and paid for night time care provision for two nights per week as a means to allow Mrs G to rest. This took place over a year after her husband's original discharge from hospital.

Appendix 2

Case study regarding top up fees for residential care

Over the last few years Trish's mother, who is living with dementia, became increasingly confused and was often found wondering the streets of Cardiff, sometimes without a coat. As her condition worsened, it became clear that she could no longer cope with living on her own.

Trish contacted Cardiff Social Services and explained that her Mum's case was now an emergency and that she needed to be placed in a home that would offer some form of safety and security. A temporary place was found for her at a care home, albeit at the opposite side of the City.

Trish's Mum was then assessed by Cardiff Social Services and found to be in need of stimulating activities because of her levels of intelligence, as well access to her own shower and toilet due to previous surgical procedures.

Three care homes in Cardiff were found to be suitable but Cardiff Social Services stated that Trish would need to agree to pay a top up fee of £550 a week before her mum could move in. Trish’s financial situation means that she has no way of meeting such a ‘top-up fee. Instead the local authority suggested a number of care homes that did not match the assessed needs of her mother.

Trish’s mother was forced to spend 10 weeks in a care home that did not meet her specific needs. Her communication skills deteriorated and she lost the means to undertake simple tasks such as using a door handle.

Finally, after a raft of letter writing and a series of frantic telephone calls, the local authority agreed to pay the top-up-fee for Trish’s mother which allowed her to move into a home that can deal with the complex needs of advanced dementia. As a result, Trish’s mum is now physically active, communicative and content.

National Assembly Wales Finance Committee: Inquiry into the cost of caring for an ageing population: UNISON response

1. Introduction

1.1 UNISON Cymru/Wales is Wales' largest public sector trade union. UNISON Cymru/Wales has 100,000 members working in public services across Wales. We welcome the opportunity to contribute to the inquiry into the cost of caring for an ageing population.

1.2 We represent full-time and part-time staff who provide public services, although they may be employed in the public, private and third sectors.

1.3 UNISON Cymru/Wales health care members are from all non-medical occupational groups including: nurses and health care assistants; midwives; health visitors; administrative, finance and HR staff; ambulance staff including paramedics, technicians, control room and maintenance staff, therapy and healthcare science staff; estates and housekeeping staff; technicians and maintenance staff; commissioning staff; allied health professionals; scientific staff; healthcare managers.

1.4 UNISON Cymru/Wales social care members include social workers and social care workers working across residential, non-residential and domiciliary care services. Our members undertake roles in early years and childcare; mental healthcare; care for older people; disabled people's care; caring for people with learning disabilities.

2 To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care

2.1 We suffer the same demographic challenges as the rest of the UK. The Health Foundation[1] estimated pressures on social care in Wales will increase by 4.1% per year over the next 15 years due to an aging population, the nature of complex and chronic conditions, and rising costs. It is worth noting also that an individual's needs may not be restricted to being elderly only and they may experience other long-standing needs, such as learning difficulties.

2.2 A Hodge Foundation Research Paper[2] identifies that:

- The proportion of elderly people in the population requiring care is projected to rise by 67% by 2035

[1] The path to sustainability: funding projections for the NHS in Wales to 2019/20 and 2030/31: Toby Watt and Adam Roberts
[2] The Promise of social care, why Wales needs a community insurance fund and how to organise it: Gerald Holtham

- The proportion of elderly people requiring non-residential care is projected to rise by 67% by 2035
- Expenditure overall will need to rise by 75-80% to account for that
- If the recent deterioration is to be reversed spending would need to double
- Social care funding would need to rise by 4% in real terms each year for most of the next two decades

2.3 There is a very evident lack of funding available for domiciliary care and residential care. Without appropriate funding it will be impossible to meet future demand. More money must be made available to the sector.

2.4 Funding pressures have led to many social care services being outsourced from local authorities to the private and third sector. This has not increased the quality of care for all patients. Instead it has created an unregulated sector where there is little incentive for employers to invest in training, a high reliance on casual and zero hour contracts, and poor terms and conditions, including low pay.

2.5 In a UNISON survey of 1,000 staff across the UK in 2017, 9 in 10 care workers said a lack of staff was to blame for work pressures with more than a quarter not having the time to help elderly people eat and drink.

2.6 When care in Wales is fragmented and under-resourced in this way, it leads to additional and unnecessary strains on the NHS.

3. To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts of arising for the UK leaving the European Union

3.1 Taking into account the terms of reference, we have concerns about the focus and direction of the inquiry. The intention to review financial pressures on social care seems to level the cause of an unsustainable system at the door of the workforce.

3.2 In our view, the costs associated with an increase in wages, automatic pension enrolment and staff recruitment and retention are a given. They should not be viewed as a financial pressure, but as a financial necessity.

3.3 Strong, efficient and effective social care services can only be delivered by proper investment in the workforce who deliver these essential services. In the long term, the cost of not investing in the workforce and not providing efficient services far outweighs any short-term financial gain.

3.4 Decent levels of pay and fair terms and conditions of employment are obviously key factors that influence recruitment and retention of staff in Wales. Workers delivering essential services need to be adequately rewarded for the important work they do. Furthermore, a stable workforce is inevitably better able to cope with fluctuating demands.

3.5 Social services and the third sector are not valued in the same way as the NHS. There is a clear need to address the disparity between the culture in the NHS and the culture in social care. In particular, ending the two-tier workforce and raising the generally inferior social care employment conditions should be a priority. In a social care setting it is often those responsible for providing direct care who experience the lowest pay, this clearly represents a problem with regards to recruitment and retention. These differences include:

- Differences in pay, terms and conditions and absence of 'levelling up' commitment;
- Differences in statutory basis for some roles across health and local government;
- Fears of losing professional identity with a generic role – this is a concern shared by residents and support staff;
- Lack of clear career pathways;
- Differences in standard assessment measures and thresholds for intervention;
- Fears around fragmentation and potential closure or privatisation of services, primarily in local government;
- Fears around continuity of funding and feelings of vulnerability outside the acute sector;
- Environmental issues around lone working, IT equipment, administrative support; the requirement for mobility and location.

3.6 The marketisation of social care has failed. There are over 400 different homecare providers but an increase in choice has not led to an increase in quality. There is also a direct correlation between the decline in the quality of homecare delivered and the reduction of funding and erosion of terms and conditions. The workforce is viewed as a product that can be squeezed in order to make profit and meet overheads rather than valued and developed in order to meet the need of the service.

3.7 In Wales, 13 of the 22 local authorities have had domiciliary care contracts handed back. We note that guidance to local authorities includes a duty to consider the third sector, but this does not include a similar duty to consider the delivery by the public sector. It is our view that this does not provide a level playing field when assessing value for money and quality of service provision and will inevitably lead to a race to the bottom.

3.8 In fact, a series of prominent third sector providers in Wales have highlighted there is no slack built into the system and they simply do not have enough money to meet the terms of their care contracts and respond to changes to employment legislation, including increased wages and enrolment in pension schemes. The commissioning process undoubtedly adds financial pressure onto the social care sector.

3.9 Local authorities have refused to release additional funding on the basis that the care contracts have already been awarded. Two third sector companies in Wales reduced sick pay benefits as a direct result of the national living wage. It is a scandal that low paid workers are caught in the middle and their conditions attacked in this manner. In addition to sick pay, payment for shift enhancements and weekend

working is under threat. Gains made on the basic rate of pay are lost elsewhere.

3.10 In relation to recruitment and retention, career pathways should be introduced to allow progression and development within, and between, a health and social care employment setting. It is essential workforce planning builds in the use of long-standing and experienced members of the workforce, but there must be a concerted focus on bringing in and developing new people.

3.11 There are countless situations where homecare workers, who often have limited training and receive minimal pay, are expected to undertake involved levels of personal care which may be inappropriate to their role, but there is no benchmark mechanism to measure this effectively. There is a vast difference between this environment and the experiences of NHS employed care workers and this is reflected in the retention rate of the workforce.

3.12 Similarly, there is a lack of recognition that minimum standards and employment conditions are also required to deliver decent care in a residential care setting. Employment levels, conditions and training directly impact the quality of care. A more stable, well-equipped workforce is essential to deliver high quality, consistent care.

3.13 Any further moves to outsource social care, in any form, should be strongly opposed. Care services must be delivered directly by the local authority. The terms and conditions of social care workers employed directly by a local authority are more favourable than their counterparts in the third or private sector. It is also worth noting that where staff are employed directly by a local authority, staff turnover is far lower.

3.14 Whilst we understand the Welsh Government is attempting to address working conditions in the social care sector, it is worth pointing out that an FOI request from UNISON Cymru/Wales in August 2016 found that only 5 out of 22 councils in Wales make it a contractual condition that the homecare providers it commissions pay their staff for their travel time. This is despite the fact that non-payment of travel time is the main reason for endemic levels of non-compliance with the minimum wage in the care sector.

3.15 For many homecare workers in particular, there is a sense of stigma attached to their work. Clearly the work homecare workers undertake is extremely valuable, but it is not recognised in the employment standards they experience. How can we realistically expect people to take on such high levels of responsibility for such low employment standards?

3.16 Quality of care must always factor as a higher priority than financial savings. The workforce is at the heart of ensuring quality services and they must be appropriately rewarded for the essential work they undertake. Furthermore, it is imperative that the entire workforce is recognised for the value they provide, the safe and effective delivery of health and social care in Wales is very much a team effort and each members of the healthcare and social care workforce contributes to that team.

3.17 Poor pay causes recruitment and retention problems. When there is a high-turnover of staff or shortages, the delivery of a quality service will always be difficult. UNISON has long advocated for the implementation of the UNISON Ethical Care Charter[3] across the sector. Analysis of UNISON's Ethical Care Charter in councils where it has been adopted had demonstrated improvements for care workers, care users and care providers. In fact, the Welsh Government supports UNISON's Ethical Care Charter in principle but have been unable to impose it due to the costs around the minimum wage at the time. Since the minimum wage has now become the National Living Wage, the cost of implementation is now significantly lower than previously and introducing the UNISON's Ethical Care Charter would be a positive approach to providing quality care in Wales.

3.18 In Islington the council found that recruitment and retention levels improved amongst its homecare providers as a direct result of the implementation of the Ethical Care Charter. Prior to introducing the charter in 2014, turnover among staff averaged over 10 per cent. Now it is less than 3 per cent. Turnover rates in social care in Wales are notoriously high and any initiative which lessens them benefits care users through improving the continuity of care. It also saves homecare providers money as they do not have to recruit and train as many new staff.

3.19 Similarly, UNISON's Residential Care Charter[4] sets out solutions to raise the standards of care within a residential environment, paying consideration to protecting and supporting residents, training and support for employees, decent pay for quality work, time to care and, essentially, providing employees with access to a recognised trade union.

3.20 We welcome the Welsh Government's commitment to focus on care as one of the four pillars outlined in the Prosperity for All: economic action plan[5] but that commitment must be resourced.

3.21 There are a significant number of EU workers for outside of the UK who form an essential part of our social care workforce. Clearly this is a situation that needs to be monitored and strategies may be required to supplement the availability of social care workers in Wales. We are aware of situations where EU workers from outside of the UK have already returned to their country of citizenship in order to have better access to the jobs market in their home country.

4 To assess the fiscal levers available to the Welsh Government to reform the arrangement for funding social care. This will include the consideration of alternative models, including international examples, for the funding of social care to ensure good quality, fair and sustainable services in a time of increasing demands on the health and social care systems

[3] UNISON's Ethical Care Charter: www.unison.org.uk/content/uploads/2016/08/22014.pdf
[4] UNISON's Residential Care Charter: www.unison.org.uk/content/uploads/2017/03/24230.pdf
[5] Welsh Government: Prosperity for All: economic action plan: www.gov.wales/docs/det/publications/171213-economic-action-plan-en.pdf

4.1 UNISON does not support the delivery of social care services outside of the public sector. We do not believe public services mutuals, i.e. outsourcing to cooperatives, mutuals or social enterprises will create any better public engagement and will undermine worker's terms and conditions.

4.2 The very limited legal framework where co-ops, mutuals and social enterprises are allowed to solely bid for in-house services within due to European Union (EU) Procurement Regulations[6], as amended in February 2014 last for three years only.

4.4 After the three-years are up, major private providers will be able to bid and take over services. This is delayed privatisation. It is highly likely the UK will retain these provisions once we exit the EU.

4.5 UNISON's experience of mutuals, co-ops and social enterprises which are "spun-out" of the public sector is that the first casualty is our member's terms and conditions. While, we are aware that the Welsh Government has reintroduced the Two-tier Workforce Code[7] to prevent this erosion, UNISON would question how a co-op, mutual or social enterprise can be financially viable while retaining existing terms and conditions.

4.6 UNISON Cymru/Wales is opposed to the 'spinning-out' of the public sector to co-operatives, mutuals and social enterprises for the following reasons:

- They can only be given a three-year contract. After the three years, open market competition applies
- Once the service is transferred out of the local authority or other public body, it becomes a private company. It will have to compete as a private company. The council or public body has lost control
- Little evidence exists that mutuals have delivered desired outcomes or true democratic control by staff and stakeholders
- We see the best provider of public services as the local authority, NHS and other state agencies
- Public service mutuals are feeding the UK Government's agenda of deceiving the public into thinking this form of 'spinning out' is not privatisation, when it is outsourcing to a new private company which could end up with no contract after three years.

[6] Crown Commercial Services: A brief guide to the 2014 EU public procurement directives: Oct 2016: www.gov.uk/government/uploads/system/uploads/attachment_data/file/560261/Brief_Guide_to_the_2014_Directives_Oct_16.pdf
[7] Welsh Government: Revised Code of Workforce Practice: June 2014: http://gov.wales/docs/dpsp/publications/140624-procurement-advice-note-v1-en.pdf

WLGA AND ADSS CYMRU EVIDENCE TO THE FINANCE COMMITTEE ON THE INQUIRY INTO THE COST OF CARING FOR AN AGEING POPULATION

JANUARY 2018

About Us

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities, the three fire and rescue authorities, and four police authorities are associate members.

2. The WLGA is a politically led cross-party organisation, with the leaders from all local authorities determining policy through the Executive Board and the wider WLGA Council. The WLGA also appoints senior members as Spokespersons and Deputy Spokespersons to provide a national lead on policy matters on behalf of local government.

3. The WLGA works closely with and is often advised by professional advisors and professional associations from local government, however, the WLGA is the representative body for local government and provides the collective, political voice of local government in Wales.

4. The Association of Directors of Social Services Cymru (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales and is composed of statutory Directors of Social Services, and the Heads of Service who support them in delivering social services responsibilities and accountabilities; a group of more than 80 social services leaders across the 22 local authorities in Wales.

Introduction

5. We welcome the opportunity to comment on the Finance Committee's inquiry into the cost of caring for an ageing population. The demographic challenges facing Wales have been well documented. Across the UK nations Wales has seen the slowest overall population growth, but has the largest and fastest growing population of older people (aged 65 and over). A 2016 OECD report confirms that although the burden of chronic and complex conditions associated with

increased life expectancy is increasing across the UK, it is higher in Wales than England[1]. Another key indicator, the levels of poverty (linked with ill health), is also higher in Wales than the other UK countries.

6. This comes at a time when local public services have faced over £1bn in cuts since the introduction of austerity measures in 2010. With service pressures running at anywhere between £150m and £300m a year, the financial position is becoming unsustainable. Councils are using their medium term financial strategies to plan for future savings requirements but there are clearly risks in terms of financial resilience, not least the burgeoning costs of social care and increasing need.

7. Social care has been identified as a sector of national strategic importance by Welsh Government Ministers and 'Prosperity for All' has identified social care as one of its priority areas with the ability to have the greatest potential contribution to long-term prosperity and well-being. This comes at the same time as the Parliamentary Review into the long-term future of Health and Social Care in Wales has reported that the case for change is compelling, with a need to create seamless health and care services for the people of Wales. We believe that an examination of the long-term future of health and social care is vital to be able to look at how we can create a sustainable and properly funded health and social care system. This will be central to developing a new approach in Wales that is fit for future generations, particularly given the current financial and demographic pressures placed on the system.

Patterns in Demand

8. The wider challenges facing social care have been well documented. As a result of demographic changes primary and community care services are facing increasing and more complex demands; more people are diagnosed with one or more preventable health condition; and frail, older people increasingly have more complex needs. This comes at a time when we continue to experience severe austerity in funding for public services across the UK.

9. Currently, approximately 70% of adults (aged 18+) in receipt of social services will be over the age of 65 and nearly a third will be over the age of 85. In addition, we know that in the wider population around 28% of those aged 85 and over are in receipt of support from social services, compared with just under 3% of people aged over 18. This highlights the significant impact that an ageing population, with increasingly complex needs, will have on services.

10. The most recent report from Wales Public Services 2025, 'A delicate balance? Health and Social Care spending in Wales' focused on the difficulties local authorities are having keeping pace with spending. The report identifies that spending on social care for the over 65's is not keeping pace with the growth in the population of older people. The increasing over-65 population in Wales

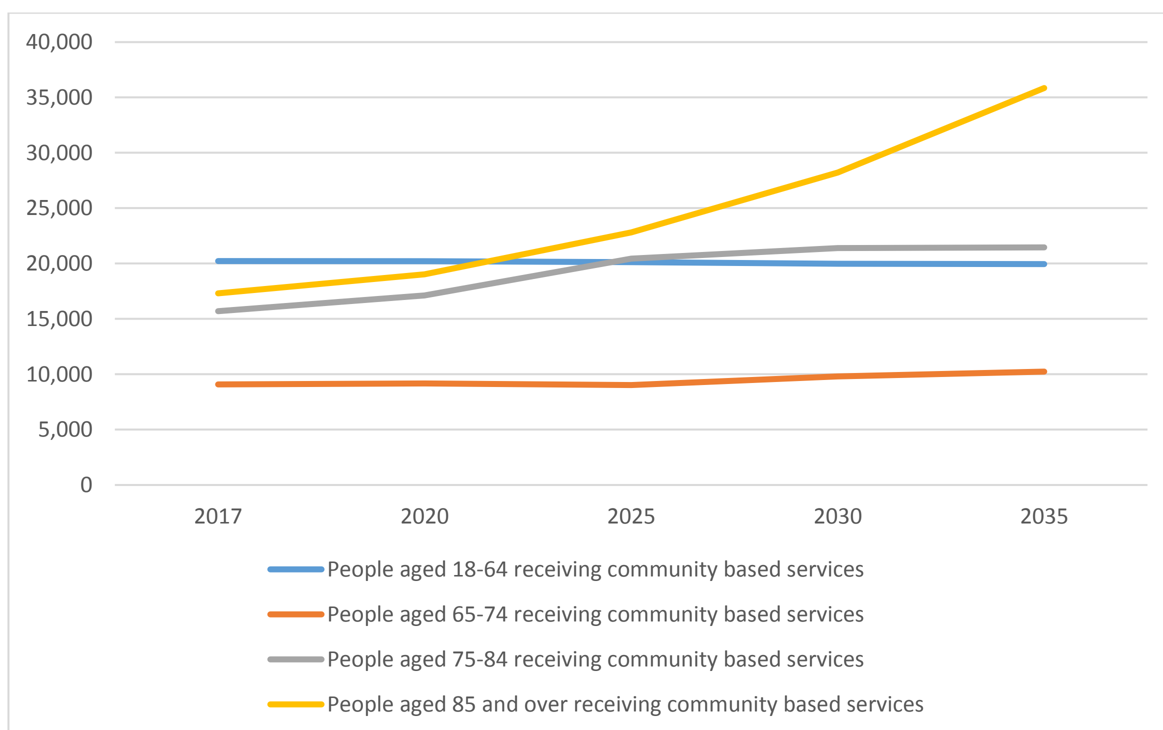
[1] OECD Reviews of Health Care Quality: United Kingdom 2016 - Raising Standards (available here: http://www.oecd.org/unitedkingdom/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm)

means that whilst day-to-day spending on local authority-organised adult social services has remained broadly flat in real terms, spending per older person has fallen by nearly 13% in real terms over the last five years in Wales, inevitably leading to impacts on services for older vulnerable people. Spending per head would have to increase by at least £129 million (24%) (2016-17 prices) between 2015-16 and 2020-21 to return to the equivalent level of spending in 2009-10, which amounts to a 2.5% year-on-year increase.

11. The report complements the findings from the Health Foundation report, 'The path to sustainability: Funding projections for the NHS in Wales to 2019-20 and 2030-31', recognising the twin challenges of financial and demand pressures faced by health and social care in Wales. The Health Foundation report also recognised that the health of the population depends on far more than just the quality of health care services. Key determinants of health are largely outside the control of health services and so the quality of, and spending on, social care has one of the strongest impacts on the demand for health care. It has been estimated that pressures on adult social care alone will rise by around 4.1% a year in real terms between 2015 and 2030-31, due to demography, chronic conditions and rising costs. This will require the social care budget to almost double to £2.3bn by 2030-31 to match demand.

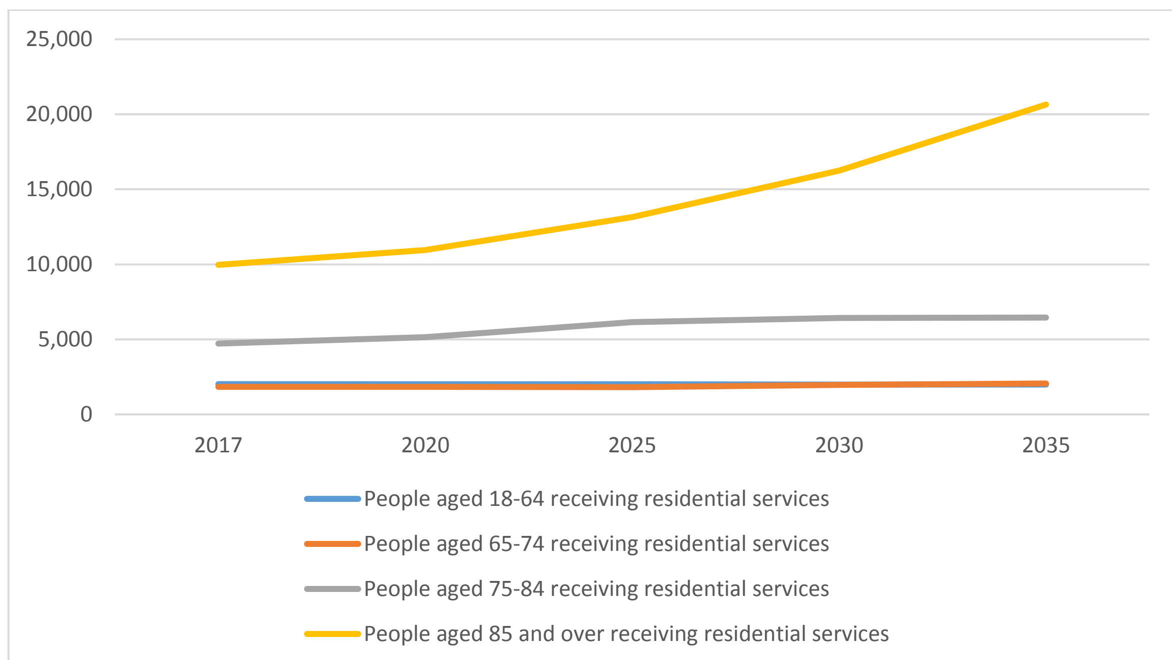
12. Population projections estimate that by 2035, the number of people aged over 65 living in Wales will increase by 33%. The largest increase will be in the number of people aged over 85 which is forecast to rise by 107% according to the Institute of Public Care's Daffodil system. The impact of these increases on some aspects of social services can be seen in Figures 1 and 2 below which demonstrate the projected increase in demand, particularly for those aged over 85, that will be placed on both social care community-based services and residential services in future years.

Figure 1: People aged 18+ receiving community-based services, by age, projected to 2035



(Source: Daffodil)

Figure 2: People aged 18+ receiving residential services, by age, projected to 2035



(Source: Daffodil)

13. The changing demographics will also impact on unpaid carers. An ageing population with improved life expectancy for people with long term conditions or complex disabilities means the need for more high-level care provided for longer. We are likely to see more older people in a caring role, with the number of carers over 85 predicted to double in the next 20 years. Increasing hours of care often results in the general health of carers deteriorating incrementally. Unpaid carers who provide high levels of care for sick, or disabled relatives and friends, are more than twice as likely to suffer from poor health compared to people without caring responsibilities. Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care, placing further pressure on our already over-stretched system.

14. All regions have published their Regional Population Needs Assessments and are currently developing their Population Area plans. All identify the important and vital role that unpaid carers undertake and are committed to improving access to suitable breaks and respite that meet the varied, often complex needs of the people they care for. Many regions are mapping or exploring more flexible options that meet specialist needs, such as autism or dementia. It is acknowledged that planning for carers services needs to consider the potential future needs of older carers and find ways of supporting older carers to plan ahead.

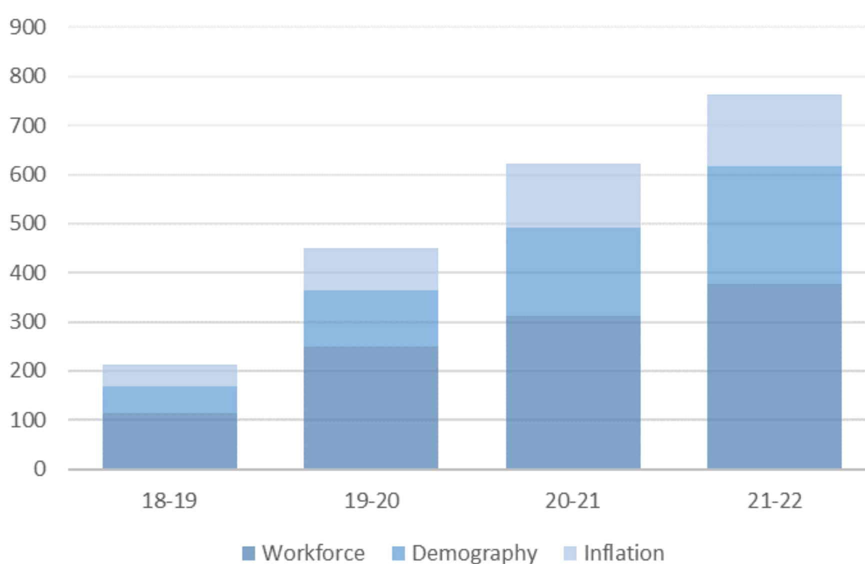
Overall Cost Pressures faced by local government

15. The higher-level longer-range forecasts produced by the Health Foundation and Wales Public Services 2025 are supported by the shorter-term estimates of the WLGA. A large proportion of supply-side pressures over the coming years are attributable to either direct workforce costs for councils, or indirect costs of third party providers. In previous years, there have been substantial cost increases such as £60m in employers' National Insurance payments due to the introduction of Single Tier Pensions in 2016-17, and £18m for the Apprenticeship levy in 2017-18. Looking forward, there are significant pressures from increased employer contributions to the Local Government Pension Scheme (£100m by 2021-22).

16. While the future of public sector pay is currently a matter of national debate, the anticipated 2% pay increase, following years of a 1% increase, are compounded by the impact of the Pay Spine Review which could add a combined 2.5% to the costs of payroll each year over a two-year period depending on the negotiations between Employers and the Unions. Altogether payroll costs will be £378m higher by 2021-22.

17. Figure 3 below shows the current assessment of expenditure pressures for local government. Total expenditure pressure for 2018-19 is higher than previous estimates at £212m. Just over half of this is the unavoidable financial pressure of pay and pensions. By 2021-22 this is estimated to rise to £762m with workforce pressures (£378m) higher than demographic pressures (£239m). Other inflationary pressure will account for £145m at the end of the same period.

Figure 3: Cumulative pressures up to 2021-22, by source, £m

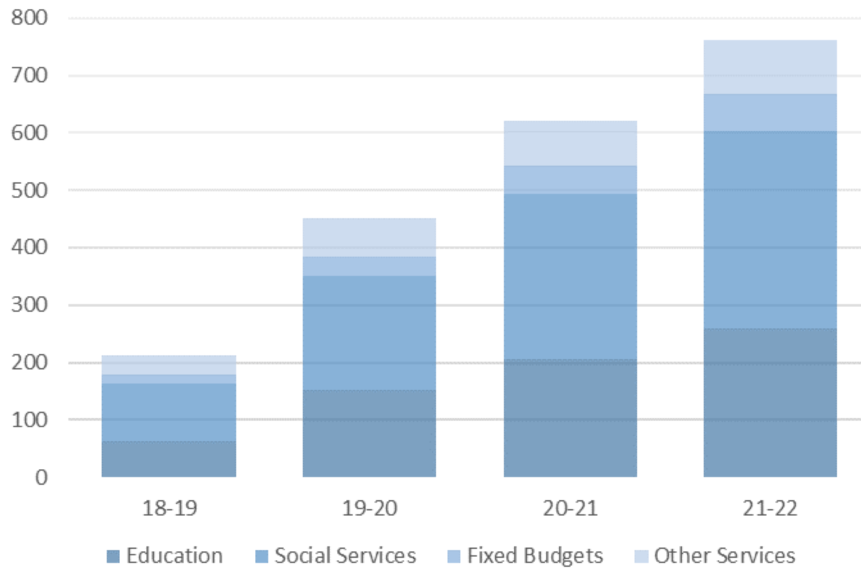


Source: Base estimates: RO and RA returns (2014-15 to 2015-16)

18. Figure 4 below shows that a greater proportion of pressure is building up in social services. An additional pressure of £99m next year becomes £344m by 2021-22. Cost drivers in the education

service rise from £64m next to £258m over the same period. Fixed elements of the budget – capital financing, fire levies and the Council Tax Reduction Scheme (CTRS) – rise from £17m to £66m by the end of the period. The remaining services are the ones most at risk and areas that have borne the brunt of austerity.

Figure 4: Cumulative pressures up to 2021-22, by service, £m



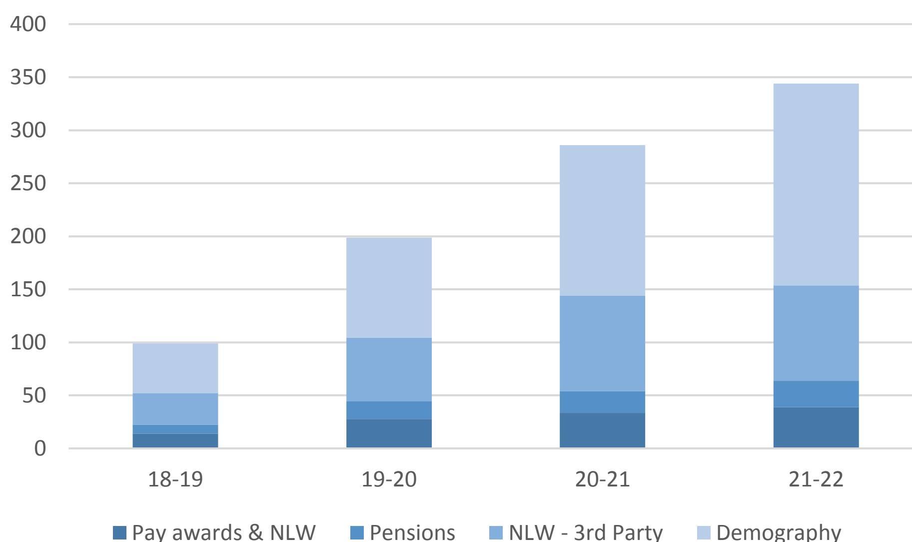
Source: Base estimates: RO and RA returns (2014-15 to 2015-16), NLW impact: WLGA Survey (2016)

Pressures specific to social services

19. In the WLGA model, we take the broader estimate of demand factors across all social services from earlier work of Wales Public Services 2025 which demonstrated that pressures drive around 2.9% growth each year. This is an increase of approximately £47m annually up to 2021-22.

20. Figure 5 below shows that within social services budgets, demographic pressures account for roughly half of the forecast growth next financial year, a proportion that increases gradually up to 2021-22. Direct and Indirect workforce pressures account for the remainder.

Figure 5: Elements of social care pressures up to 2021-22, by service, £m



21. Pressures due to social care continue to pose the most risk to council's financial sustainability in the medium to long term. The current funding arrangements will not cover the expected increases in cost and demand facing social services. Local government's spending pressures will total around £212m in 2018-19 which will have to be either fully absorbed by councils (or cuts made elsewhere) or partially offset by council tax increases.

22. A knock-on impact of the pressures being faced within social care has meant that the provider market has been fragile for some time and all the signs are that the difficulties will only increase. For example, 13 of the 22 Welsh local authorities have reported domiciliary care contracts being handed back to them. For some areas of Wales it can be very difficult to access domiciliary care to respond to complex cases or because of the rurality of the area, with local authority provision having to fill the gap, often with difficulty.

23. There are a series of factors that have increased or will further increase the costs of providing care services, including:
    - National Living Wage
    - Sleeping in judgement
    - Pension changes
    - Travel costs
    - Impact of HMRC changes

24. The pressures on social care are the most significant, immediate and direct for local authorities but we need to recognise the importance of other council services, which are all involved in helping to meet the demands placed on both health and social care services. Services such as

libraries and leisure centres have increasingly been playing a part in supporting older people to stay well and independent. We also know that suitable housing can significantly improve life in older age, while unsuitable housing can be the source of multiple problems and costs. There will continue to be a need for high-quality nursing and residential care for those who need it, as well as a need to consider alternatives such as enhanced support at home. Appropriately designed housing that can adapt to people's changing needs as they age has a number of benefits, including reducing demand on health and care services. We firmly believe that that there is a real need for investment in housing for older people to both improve existing provision and plan new and creative ways of delivering suitable accommodation, tailored to the needs of whole sectors of our communities. Enabling us to be able to meet the changing needs and demands being placed on our services.

25. We retain a firm belief that investment in preventative services must be the core priority for Welsh Government, in line with the philosophy of both the Social Services and Well-being Act and the Wellbeing of Future Generations Act and in terms of sound budgetary policy. Many preventative services in local government, such as leisure centres, parks, adult education, youth work and community facilities are provided at the discretion of local councils. Unfortunately, in recent years it is these preventative services that have faced the brunt of cuts to local authority budgets as statutory services such as education and social services have been protected. The recent report by Wales Public Services 2025, 'Austerity and Local Government in Wales: an analysis of income and spending priorities, 2009-10 to 2016-17', highlighted the significant impact that eight years of austerity have had on local public services. Cuts in the smaller but vital services have been deep, with question marks over their future sustainability if a further period of cuts were to continue.

26. At the same time in the NHS, available funds have been targeted at delivering improved performance in secondary care services, most notably to address referral to treatment waiting times. Pressure on hospital services has never been greater and NHS organisations have therefore struggled to redirect resources into preventative services based in primary and community settings.

27. The Welsh Government's investment in the Intermediate Care Fund (ICF), now the Integrated Care Fund, has been welcomed by local government and has led to the introduction of a number of preventative services across Wales, with older people with complex needs and long-term conditions being one of the priority areas for the fund. All regions have reported that the ICF has developed a culture of collaboration with improved communication and decision making across all sectors. There is an enhanced understanding of what different partners can provide, with improved knowledge of good practice within the region that can be developed and shared more widely. The fund has also increased capacity to improve outcomes for people and to deal with demand for services. Some areas of good practice include single point of access, the establishment of intermediate care teams (ensuring the provision of co-ordinated services across health and social care), rapid response teams, social care or third sector staff working alongside

health staff in hospital to prevent delayed discharges, extending the range of rehabilitation / reablement services (including the use of intermediate care flats as part of a wider health, social care and community complex).

28. Its success comes from providing dedicated resources, supported by focused leadership, joint decision-making and governance, to enable public services to concentrate and deliver transformational change. The introduction of the ICF has evidenced the benefits of joint planning and joint decision making and we believe more can be done. For example, by increasing the funding available through the ICF or by bringing oversight of the Primary Care Fund under the newly established Regional Partnership Boards, as the ICF currently is, to enable us to fully examine opportunities for integrated working.

29. All accept that it is not just about chasing pots of money. It's about identifying money and people that are not already entangled in sector pressures or rules that can be used to achieve something new while at the same time trying to at least maintain, if not improve the level and quality of existing services.

Arrangements for Funding Social Care

30. On-going financial austerity measures for local authorities mean that there is little scope for cost pressures to be reflected adequately in prices paid for care in the near future. Increases in costs cannot be absorbed by care providers indefinitely (nor cross-subsidised by self-funders) and unless a more strategic and sustainable solution is found, there will be significant consequences across the social care market.

31. Social Care Wales have developed a five-year strategic plan covering care and support at home in Wales. This plan recognises the need for a systematic change to the way care and support at home is provided. The strategy identifies the need for Welsh Government to realign funding and to explore the options available to increase and maximise the resources invested in care and support at home.

32. The Care Inspectorate Wales (formerly Care and Social Services Inspectorate Wales) review of domiciliary care supports this view, noting that whilst simplifying and standardising processes will make some parts of the system more efficient and may save some money, it will not be enough on its own. More money needs to be made available in the system so that in years to come there is a resilient, competent workforce and quality provision of care.

33. While medium-term financial planning is firmly embedded and improving in local authorities, longer term thinking is still at a nascent stage, though there are positive signs the Wellbeing of Future Generations Act is proving to be a useful lens through which to view future service provision. Some authorities are starting to undertake strategic programmes of 'whole-authority' work. For example, 'Future Monmouthshire' aims to pose a set of questions about the

authority's core purpose, relationships with communities, citizens and stakeholders and its appetite for economic growth and local prosperity.

34. One of the aims of programmes like this is to develop a new operating model in order to equip authorities to meet their goals amidst increasing change and uncertainty. The new operating model will have a clear purpose: to create the capacity and foresight to develop solutions to some of the biggest challenges, ensuring that authorities understand the shifting needs and priorities of communities and positioning themselves as enablers for change.

35. We cannot continue as we have done in the past eight years of austerity where the additional funding for social care has to be found from a mixture of council tax increases and funding from discretionally areas. In his Financial Resilience Report, the Auditor General has calculated that between 2010-11 and 2016-17, there was a real-terms reduction of £761 million (17%) in aggregate external finance (core grant) for local government. This has had varying impacts across local public services with some experiencing real terms reductions of over 50%, and spending at levels not seen since the 1990s.

36. Given the significant pressures being faced there is a growing consensus that social care is such a significant challenge that new thinking on funding is required. The crisis facing social care was quite rightly a major issue during the general election campaign, and reflects how deeply concerned the public are about how we care for older and disabled people. Fundamental changes to the way we fund social care are needed if we are to deliver a long-term sustainable system that works for everyone in society and meets their needs with safe and high-quality services. Difficult, brave and possibly even controversial decision-making will be required to secure the long-term future of care and support, not just of older people, but people of all ages.

37. This is not a new debate, in 2013 for example, the then Deputy Minister for Social Services commissioned research from LE Wales on paying for care in the Welsh context which included data on current charging, present and future population composition, and trends in income and capital. Two research reports were published, the first in April 2014. The report provided data on population trends in Wales and projections of current and future demand for care services. It also included data on expenditure on, and income from, care services, and on charging arrangements across Wales. The report also looked at alternative models for paying for care and considered the arrangements in other countries including France, Germany, Sweden, Japan and Australia. The second LE Wales report, published in October 2014, provided projections of demand for, and the costs of, care under a number of scenarios over a 25-year period from 2013 to 2037. This second report also set out the possible impacts of a variety of policy options for both residential and non-residential care. Five policy options were considered:
    - Option 1: All care costs are paid through government expenditure
    - Option 2: Set Government contribution
    - Option 3: Weekly maximum on self-funders' contribution
    - Option 4: Lifting housing assets threshold

- Option 5: Lifetime cap on care charges

The report also looked at some potential financial services products and state funding options, such as a social insurance fund.

38. In their recent paper for the IWA, Solving Social Care, both Professor Gerry Holtham and Tegid Roberts suggest a common insurance fund to pay for the growing costs into the future. Another suggestion by the Financial Times commentator, Merryn Somerset Webb proposes capping the fees of the asset management industry to free up funds for social care. Both are interesting interventions into this debate and need serious examination.

39. We have welcomed the Cabinet Secretary's recent proposal to use the Welsh Government's new tax-varying powers to look at funding a social care levy. There is a need to focus on long-term funding solutions such as this proposal and look at how to build political and public support for them. Extra funding for social care can empower councils to prioritise prevention work which is key to reducing the pressures on the health service and keeping people out of hospital in the first place so they can lead fulfilling and independent lives in their communities and close to their loved ones, which will reduce costs to the public purse.

40. An essential foundation for long-term reform is greater awareness amongst the public of why social care matters in its own right. Everyone who has a stake in our care system should help build this awareness. Similarly, progress is only likely to be made if there is cross-party consensus on a way forward. There is a need for an open and frank discussion around the proposals and options, with a need to fully engage with the public on the issue led by Welsh Government.

41. It is important to remember that the policy options that we consider do not change the total cost of the care system, rather they change the way in which those costs are paid for and by whom and that while planning for the future, and to pave the way for long-term reform, we must address more immediate short-term pressures, such as the fragility of the care provider market.

Conclusion

42. We believe there is a clear need for Welsh Government to fully recognise and address the immediate funding pressures facing the social care sector. Whilst the relative protection in funding provided to local authority social services has been welcomed, on too many occasions the approach to providing additional funding for the NHS has been to take from one to pay for the other, with social care experiencing reduced budgets in order to protect the NHS. The demand for NHS services cannot be isolated from the quality of other public services – the sustainability of the NHS is intertwined with the sustainability of other public services, most crucially social care.

43. We recognise all the built-up pressures and demands on the Welsh budget. The position in the NHS is also fully acknowledged. It is the case however that the health budget has had a level of significant protection which has seen increases over the past 5 years. The local government budget conversely is now back at its 2004-05 levels. Bearing in mind the scale of the pressures in this paper this fact must be at the forefront of budget considerations over the next five years.

44. Social services are one of our most vital public services, supporting people of all ages across a wide spectrum of need to live as independently as possible and providing valuable protection from harm in vulnerable situations. In a world of increasingly limited resources and ever increasing demand, there is a need for the Welsh Government to turn their ambition of social services being a sector of national strategic importance into a reality. Investment will improve outcomes for the most vulnerable people in society helping to ensure the sustainability of the social care market and having a significant positive impact on people's lives.

FOR FURTHER INFORMATION PLEASE CONTACT

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Care & Repair Cymru

Gwella cartrefi, newid bywydau
Improving homes, changing lives

Finance Committee
National Assembly for Wales
Cardiff Bay
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The Cost of Caring for an Ageing Population

Written evidence submitted by Care & Repair Cymru: January 2018

Introduction to Care & Repair

1. Care & Repair Cymru aims to ensure that all older people have safe, warm, accessible homes in which to live independently, with dignity for as long as they want. We are specialists in developing and delivering housing solutions that make this possible.
2. Our network of local agencies delivers trusted, practical, frontline services throughout Wales. Multi-disciplinary teams of caseworkers, tradespeople and qualified surveyors provide advice on adaptive work, home repairs, improvements and energy efficiency, access grants, charitable funds and unclaimed welfare benefit entitlements, and undertake practical repairs, maintenance, disability adaptations and more complex home improvements. This combination of person-centred casework and technical housing expertise makes our service unique.
3. Care & Repair Cymru supports and represents local agencies. We ensure consistency across Wales, monitoring and evaluating outcomes, and raise awareness of our services and of older people's needs. We develop and pilot innovative approaches and delivery models, helping to lever additional resources into frontline work. We reach across housing, health and social care to support integrated policy thinking and make the case for the effectiveness of strategic public/third sector partnerships and greater investment in our services.
4. Last year, Care & Repair agencies delivered £13 million's worth of physical alterations and adaptations to improve the health, safety and warmth of 28,500 homes. Our work gives us a unique insight into the needs and lives of Wales's older people. We welcome the opportunity to respond to this important inquiry.

Patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care.

Older people – a holistic approach to social care

5. There are 634,637[i] people over the age of 65 living in Wales today with an average life expectancy of 20.5 years for women and 18 years for men[ii]. The

prevalence of chronic health conditions and disability experienced by older people is higher than the population as a whole – and varies across Wales:

- 60 percent (323,011) of older people have a long term health condition or disability that significantly limits their day-to-day activities;
- 71 percent of those over 70 have some hearing loss and one half of those in their 90's have a visual impairment[iii]; one in five older people is affected by depression[iv]; one in five older people is in receipt of a disability benefit[v];
- one in six (111,577) older people receives social care in Wales[vi] - accounting for almost half of the adult social care budget and 8.3% of the entire local government budget[vii].

6. However, this focus on poor health, disability and care costs as the defining characteristics of old age misrepresents the reality of most older people's lives:

- 59% describe their overall health as good, very good or excellent;
- 10% are in paid employment and 15% are carers[viii];
- the net contribution of older people to the Welsh economy has been valued at over £1billion a year, almost £3million a day through, amongst other things, taxes, spending power and the value of their volunteering[ix].

7. The costs of caring for our ageing population require placing in a context that also acknowledges the invaluable role played and rich contribution made by older people to their families, communities and the economy. These benefits should be factored into any calculation of care costs and form the basis of an holistic social care agenda that starts with home and community-based, preventative strategies to maintain older people's activities, health and wellbeing for so long as possible.

The nature of demand

8. Care & Repair Cymru would draw the Committee's attention to the fact that 81% of older people live independently, in mainstream, owner-occupied properties and 3% of older people in residential care homes[x]. These statistics reflect our experience that the overwhelming majority of older people not only want but are able to manage in their own homes with appropriate levels of support from their families, local communities and local services. That is not to say that residential care is not a vital and essential resource for those who need it but, if the social care needs of all our older people are to be met, non-residential care requires the highest strategic attention – so too, crucially, the quality of the home into which it is delivered.

Minimising demand - the role of housing

9. Housing has a direct influence over people's health and wellbeing, and the quality of older people's homes has a direct relationship to the need for social care. Our work, with over 30,000 older people across Wales every year, gives us a first-hand experience of the fundamental importance of the 'right home' in maintaining older people's independence, facilitating social lives, physical activity levels and mental wellbeing, and minimising social care needs and costs.

10. Older people spend proportionately more time at home and are especially vulnerable to the many, life-limiting health risks presented by Wales' comparatively old housing stock:

- an estimated one in four older people's households are in fuel poverty, paying more for their energy costs, heating poorly insulated homes with inefficient

- heating systems[xi] - poorly heated homes are directly implicated in respiratory and circulatory conditions and excess winter deaths[xii];
- 29% of older people live in a house with a Category 1 hazard which presents significant risk to the health of the occupant - 13% of older people's homes present a risk of falling and 11% present a risk of excess cold[xiii].

11. Home-based adaptations and 're-abling' housing solutions promote health, prevent hospital admission, facilitate hospital discharge and avoid residential care. For comparatively small sums, they also minimise the costs of social care, maximise the contribution of unpaid care and enable older people's highly prized independence:

    - the cost of falls to the NHS is estimated at £67m a year[xiv] and the cost of a hip fracture, in terms NHS care alone, is nearly £29,000 in addition to ongoing social care - the installation of hand and grab rails to reduce the risk of falling can be less than £300;
    - the installation of a disabled toilet and wetroom at a cost of £10,000 is equivalent to 14 hours care per week to supervise washing[xv];
    - a £6,500 Disabled Facilities Grant allows an older person to continue living at home for four more years, saving over £100,000 in residential fees;
    - for every £1 spent on Care & Repair's delivery of the Rapid Response Adaptations Programme, £7.50 is saved from health and social care budgets[xvi].

The financial impact of current Welsh Government policies - including recent social services legislation and reforms to social care funding - on local authorities, care providers and service users.

Strategic policy

12. Welsh Government has sought to build a secure strategic framework of support for older people - the Strategy for Older People in Wales, the Ageing Well in Wales Programme and the local government network of Older People's Strategy Co-ordinators. Yet, our caseworkers still receive referrals of extremely vulnerable older people living in inadequate housing for which there is no public sector support.

13. We are further frustrated, despite new legislation and initiatives built on sound principles, at the lack of progress towards genuinely holistic local approaches that integrate budgets and services, foster innovation and engage the third sector:

    - the Social Services and Well-being Act 2014 - we have contributed to Age Alliance Wales' evidence gathering on our experience of the Act to date and refer to the Committee to that submission;
    - the Integrated Care Fund – designed to fund joint projects covering health, social services, housing and third sector to support older people and maintain their independence, we remain concerned that the fund has focussed on integrating public sector services rather than exploiting the opportunity to deploy genuinely cross-cutting, person-oriented, innovative third sector models – or capitalise on the potential for scale following successful pilots.

Public spending

14. We recognise that Welsh Government and local authorities have sought to protect social services budgets in recent years and limit weekly care charges with higher

capital disregards. Neither these nor the policies above have proven sufficient to counteracting the real terms reductions in the context of demographic change. Most disappointingly from a strategic perspective is the disproportionate impact on preventative, enabling solutions that support independence:

- Wales Public Services 2025 describes the per-capita spend on social care as showing "*a precipitous decline per-adult aged 65 and over*" – a fall of 12% in real terms since 2009/10. Further, it analyses the changing nature of the spend: the proportion spent on direct payments for community care has almost trebled whilst net spending on meals for older people and support for care equipment and home adaptations has decreased (by 59% and 42% respectively).[xvii]

Future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age.

Demographic change

15. Wales has the largest and fastest growing proportion of older people in the UK - the demographic profile is changing with important local variation in detail:

- by 2039, one in four of the population will be over 65 - a 44% increase in the age group;
- by 2030, the percentage of the population aged over 75 will increase from 9% to around 13%[xviii];
- as older people live longer, more are likely to experience age-related neurological and sensory conditions – by 2025, there could be 50,000 older people aged 65 or over living with dementia;
- the older population will be proportionately larger in rural areas where 54% are currently aged over 45 years compared to 48% in small towns and 42% in large towns[xix];
- there are clear differences between Wales' most and least deprived areas in terms of life expectancy (8 years) and 'healthy' life expectancies (18 years).

16. It is widely anticipated that the growth in number of very older people with age-related disabilities, chronic conditions and multiple health conditions will increase the need for care – Wales Public Services 2025 estimates the need for a 2.5% annual increase in social care spending to return the per capita spend on local authority social services for over-65s back to 2009-10 levels[xx].

17. We would highlight the implications for the way in which services require framing and delivering in line with the particularities of need – and to ensure that the limited resources reach further than ever before:

- Managing Better, is a lottery funded, third sector collaboration between Care & Repair Cymru, RNIB Cymru and Action on Hearing Loss Cymru. The project works pro-actively with health and social care services to identify and help older people with sensory loss before they reach crisis point at home. It brings the partners' respective knowledge, skills and approaches to deliver specialist housing interventions across Wales. In its first year, the project supported 1,425 people, 12 percent referred by GPs or hospitals and 36 percent by health and social care workers.

Growing poverty

18. There is also evidence that, after two decades of improvement, pensioner poverty is rising and at its most acute in Wales where poverty rates have increased from 12% of pensioners in 2010/11 to 21% in 2015/16 (compared to 16% in England, 14% in Scotland and 11% in Northern Ireland[xxi]. Already in Wales:

- 118,000 pensioners are living in relative poverty[xxii] and an estimated 58,000 in persistent poverty[xxiii];
- a greater proportion of older people in Wales are reliant on 'top-up' benefit, Pension Credit, to lift them out of poverty – its value has not been 'triple lock' protected and is now worth less than it was in 2009/10 and will reduce further;
- an estimated one in three older people are not claiming their Pension Credit entitlement[xxiv] - last year, our caseworkers increased older people's incomes by £4.8 million in unclaimed benefit.

19. This year, a survey of Care & Repair caseworkers identified two emerging poverty traps: older people on low incomes but just over the Pension Credit means test who miss out on passported additional benefits, and an upcoming generation of older people who, in their late 50's and 60's are on low incomes with no savings, struggling to pay mortgages, support families and maintain their homes. The survey suggested a growing number of older homeowners who simply cannot afford the capital costs associated with ensuring safe, warm, accessible homes:

> *"There are probably hundreds of vulnerable people who are just over the threshold for means tested benefits and who have very little or no savings (very little meaning they won't part with their 'funeral fund') …. Most older people, couples or single, don't have family to support them with the cost of repairs or heating their homes"*

> *"I have a lady whose daughter has said she will have to go in to a care home if they can't get the boiler replaced. I am currently looking into this case and hope it will not come to this*"

Housing and future generations

20. Housing is of such central importance to older people's health, wellbeing and care needs, that it must be at the heart of any meaningful strategy to address older people's social care. The Future Generations Commissioner has addressed the importance of the home to well-being and the need to consider ageing in wider, societal terms. She has urged a shift in service delivery to encourage community based solutions to empowering older people and promoting age-friendly communities[xxv]:

> *"public bodies need to be thinking about how their services enable the development of communities that enable and empower older people to contribute and to participate, enabling positive, preventative outcomes that help maintain their health, independence and well-being."*

21. Yet, there is an accumulation of evidence[xxvi] testifying to the lack of provision in the context of ageing and resulting changes in households. Welsh Government, local government and the social housing sector are, understandably, focussed on the affordable (social) housing challenge for working age families. But this fails to address the greater demographic demand, the housing needs of older people, or to recognise the importance of the private sector which dominates the housing

landscape. Welsh Government and local government need to review their strategic emphasis and influence to take proper account of the ‘new’ housing market as the population shifts and closer relationships require forging between housing, health and social care.

To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care. This will include the consideration of alternative models, including international examples, for the funding of social care to ensure a good quality, fair and sustainable service in a time of increasing demands on the health and social care systems

22. Care & Repair Cymru welcomes the debate around alternative mechanisms for funding social care but urges Welsh Government not to lose sight of the fact that UK government policies – in particular over welfare, taxation and pensions – will continue to exert the greatest influence over public sector spending into the future. Indeed, the Office for Budget Responsibility identifies other factors, beyond demography, as bearing chief responsible for driving up demand on health (and social) care spending[xxvii]. New taxes or levies on people in Wales are no fair substitute for strong representations, on the part of Welsh Government, in relation to the needs element of the new fiscal framework.
23. More specifically, we urge Welsh Government and local government to consider their existing fiscal powers, policies and well-being responsibilities with a view to increasing their investment in older people’s housing, particularly private housing, as the bedrock to effective social care provision. We commend the Committee’s attention to the priorities, actions and innovations identified in the Expert Group on Housing an Ageing Population in Wales[xxviii]. These have a key role to play in aiding independence and minimising social care costs – but require national and local investment as a matter of urgency.

To consider the findings and conclusions of the Parliamentary Review.

24. Care & Repair Cymru welcomes the Review’s recommendations. They are reassuring in endorsing the existing policy framework which, in our view, already has the potential to reshape health and social care but on which progress has been frustrating – particularly in relation to collaborating with the third sector and mainstreaming innovation. We agree that faster, more determined progress towards integrated, co-produced, individually tailored services is required.
25. The Review has included housing within its concept of ‘seamless care’, specifically citing the importance of adaptive and preventative interventions in the home. These emphases and the importance of orienting health and care services around homes and communities are crucial.
26. We also recognise that the Review challenges us, on older people’s behalf, to expand our services, innovate further, collaborate more widely and coproduce more meaningfully. We hope that the new national ‘templates’ and regional reconfigurations proposed by the Review prompt new opportunities for Care & Repair to play a greater role in transforming the lives of older people across Wales.

[i] https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/nationallevelpopulationestimates-by-year-age-ukcountry
[ii] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2014to2016#life-expectancy-at-older-ages
[iii] https://www.nomisweb.co.uk/census/2011
[iv] https://www.ageuk.org.uk/pagefiles/7010/Older_people_in_Wales_key_facts_and_statistics.pdf?dtrk=true
[v] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/600594/pensioners-incomes-series-2015-16-report.pdf
[vi] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Adult-Services/Service-Provision/adultsreceivingservices-by-localauthority-clientcategory-agegroup
[vii] http://www.walespublicservices2025.org.uk/files/2017/03/Wales-health-and-social-care-final_amended_04-2017.pdf
[viii] https://www.ageuk.org.uk/pagefiles/7010/Older_people_in_Wales_key_facts_and_statistics.pdf?dtrk=true
[ix] http://www.cpa.org.uk/cpa-lga-evidence/Merthyr_Tydfil_County_Borough_Council/Ageing_Well_in_Wales_Programme.pdf
[x] 2011 ONS Census Data
[xi] http://gov.wales/docs/caecd/research/2016/160711-production-estimated-levels-fuel-poverty-wales-2012-2016-en.pdf
[xii] http://gov.wales/docs/caecd/research/2017/170404-fuel-poverty-data-linking-project-findings-report-1-en.pdf
[xiii] http://gov.wales/docs/statistics/2009/091130livingwales2008en.pdf
http://gov.wales/docs/statistics/2009/091215housing2008en.pdf
[xiv] The cost of poor housing in Wales – BRE/Shelter, 2011
[xv] https://www.moneyadviceservice.org.uk/en/articles/care-home-or-home-care#comparing-the-cost-of-care
[xvi] http://www.careandrepair.org.uk/files/9914/9194/0579/Healthy_Homes_Healthy_Lives_-_Good_Practice_Guide.pdf
[xvii] http://www.walespublicservices2025.org.uk/files/2017/03/Wales-health-and-social-care-final_amended_04-2017.pdf
[xviii] http://gov.wales/docs/statistics/2017/170505-future-trends-report-2017-en.pdf
[xix] https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf
[xx] http://www.walespublicservices2025.org.uk/files/2017/03/Wales-health-and-social-care-final_amended_04-2017.pdf
[xxi] https://www.jrf.org.uk/report/uk-poverty-2017
[xxii] With an income of less than 60 per cent of the wider population's median income.
[xxiii] Living in relative income poverty in 2015-16 and in at least two of the three preceding years.
[xxiv] https://www.ageuk.org.uk/pagefiles/52140/Life%20on%20a%20low%20income%20-%20FINAL%20-%20E.pdf?epslanguage=en-GB-CY?dtrk=true
[xxv] http://www.olderpeoplewales.com/Libraries/Consultation_Responses_2017/May_2017_NAfW_ELGC_Committee_Inquiry_Poverty_in_Wales_Communities_First_ENGLISH.sflb.ashx
[xxvi] the Welsh Housing Supply Task Force reported significant under delivery of new homes against projected need whilst the Public Policy Institute for Wales has identified the need for "an above trend increase in housing supply"; the Older People's Commissioner has queried the extent to which non-residential alternatives have been explored: "the potential for further development of other models that combine housing and care, such as extra care."
[xxvii] http://obr.uk/docs/dlm_uploads/Health-FSAP.pdf
[xxviii] http://gov.wales/docs/desh/publications/170213-expert-group-final-report-en.pdf

Cost of caring for an ageing population

Carers Trust Wales exists to improve support, services and recognition for unpaid carers in Wales. With our Network Partners – local services that deliver support to carers – we work to ensure that information, advice and practical support is available to carers across the country.

Carers Trust Wales delivers practical support and information to carers and to those who work with them including: schools, social workers, nurses, pharmacists and physiotherapists. We also seek to influence decision-makers, the media and the public to promote, protect and recognise the contribution carers make, and the support they deserve.

We welcome the opportunity to contribute to the Finance Committee's inquiry into the cost of caring for an ageing population.

Whilst we are not best placed to comment on all aspects of the inquiry's terms of reference in detail, we believe that the below evidence falls within the scope of the inquiry, providing a broad insight into the challenges facing un-paid carers in Wales.

Key recommendations:

- Develop mechanisms to suppport uptake of Carers Allowance so it is actively encouraged and promoted in Wales and consider the potential benefits of seeking to devolve relevant legislative tools to Wales (including Carers Allowance)
- Introduce a national Carer Well-being Fund to provide for greater flexible 'respite' and breaks for carers across Wales, coordinated by the third sector and delivered in partnership with local authorities and local health boards.
- Press the Welsh Government on the capacity and ability of local authorities and health boards to deliver the duties outlined for carers in the Social Services and Wellbeing (Wales) Act
- A significant shift in funding to support local authorities deliver preventative services and long-term consideration of the role of the third sector in planning to support older carers over the next 30 years

To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care;

To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age;

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To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care. This will include the consideration of alternative models, including international examples, for the funding of social care to ensure a good quality, fair and sustainable service in a time of increasing demands on the health and social care systems;

Scale of the contribution made by carers

1. 3 in 5 of us will become a carer at some point in our lives. There are millions of unpaid carers providing support across the UK with the last census showing that there are at least 370,000 in Wales: the highest proportion of carers in the UK.[1]

2. In almost every category, Wales has the highest proportion of carers in the UK – including the highest proportion of older carers and the highest proportion of carers providing over 50 hours of care a week.

3. One in five people aged 50–64 are carers in the UK. 65% of older carers (aged 60–94) have long-term health problems or a disability themselves. 68.8% of older carers say that being a carer has an adverse effect on their mental health. One third of older carers say they have cancelled treatment or an operation for themselves because of their caring responsibilities.[2]

4. Unpaid carers contribute £8.1 billion to the Welsh economy each year (this is calculated at the cost of an hour of unpaid care being paid at the minimum wage) and it is important that this valuable contribution is recognised and appreciated.[3]

Support currently available

5. Whilst Welsh Government has made great progress towards better supporting carers through innovative policy and legislative change, recognition and implementation has been slow and inconsistent. Too often, there has been a failure to understand the complex relationship that exists between carers and services and the importance of developing systems and structures that recognise, support and empower carers both to deliver good care and to prioritise their own wellbeing and life goals.

6. Strong legal rights, for example those delivered through the Social Services and Wellbeing (Wales) Act, have yet to be consistently delivered to the spirit and letter of the law at the point of implementation. For example, Carers Trust Wales and our local Network Partners, have been made aware of waiting lists for carers needs assessments, low levels of awareness amongst carers of their entitlement to an assessment or a clear understanding of when an assessment has been

[1] https://carers.org/key-facts-about-carers-and-people-they-care
[2] https://carers.org/key-facts-about-carers-and-people-they-care
[3] https://www.carersuk.org/for-professionals/policy/policy-library/valuing-carers-2015

undertaken. In some cases, “what matters” conversations are being held instead of formal needs assessments and carers have reported being steered away from a needs assessment because services would not be available to meet support needs should they be formally identified.

7. Carers Wales’ Track the Act briefing provides clear evidence to support our concerns regarding the extent to which the Social Services and Wellbeing (Wales) Act is ensuring that Carers’ needs are being identified and met in all Local Authorities across Wales.[4]

Why supporting carers is a good investment

8. Carers are unpaid. Carers are not, however, “cost-free”. They require care and support in their own right to enable them to care without risking their work, health and wellbeing. It is important, when considering the cost of caring for an ageing population, that meeting the associated needs of unpaid carers is expressly factored in.

9. Carers’ own health and wellbeing needs are often exacerbated or caused because of their caring role.[5] If carers’ health continues to deteriorate it will have a negative impact on their own wellbeing, and also the wellbeing of the person or people they care for. It may also have an impact on the health and social care services as they may be required to provide unplanned, emergency care to the people with care and support needs.

10. The un-paid work of carers props up the health and social care system in Wales[6]. If we do not move quickly to get the right support, to the right people, at the right time, significant additional pressures will inevitably be placed on health and social services as more and more carers feel forced to give up their unsustainable caring roles.

11. Supporting carers appropriately delivers benefits for carers and the people they care for. For example:

    - supporting carers by providing breaks and emotional support helps to prevent burnout and keep carers caring for longer;
    - working to encourage carers into or to continue in education improves their emotional well-being and personal fulfilment as well as widening their options for future employment, education or training;
    - involving carers in hospital treatment and clinical decisions improves communication and planning which results in better outcomes for both patient and carer.

[4] https://www.carersuk.org/files/section/5763/track-the-act-briefing-2-final-draft-year-1.pdf
[5] http://static.carers.org/files/in-poor-health-carers-uk-report-1674.pdf
[6] http://www.wales.nhs.uk/carers

However, too often carers are not supported in any of these ways.

12. The roles undertaken by carers are of clear benefit to the Welsh economy and contribute to easing pressure on local authorities and NHS Wales in a challenging financial climate. To maintain their caring role, and their own health and wellbeing, different carers need different kinds of support.

13. The specific support individual carers need to thrive will be as diverse as their circumstances. In our experience, this can range from requiring better information on managing medicines to having access to reliable services to provide a much-needed break from caring.[7] However, the first step in delivering appropriate support will always stem from individuals and professionals being equipped with the information and tools they need to identify carers and to understand the barriers they face.

14. Failing to address the pressures currently facing carers will undoubtedly have economic consequences. Additionally, failure to change will risk the health, wellbeing, financial security and life chances of a whole generation of carers. Carers provide 96% of care in the communities of Wales and too often their own needs are not acknowledged or met[8].

15. We believe that in order for vital health and social care services to survive carers and the services they rely on must be placed on a sustainable footing and given the tools to thrive.

16. In England, the Royal College of General Practitioners has worked with Baker Tilly to identify the social return on investment which can be made when CCGs invest in services which support carers. The study shows that this could equate to a saving of almost £4 for every £1 invested.[9]

17. Adittionally, an Impact Assessment published by the Department of Health in England in October 2014 makes an estimate of the “monetised health benefits” of additional support for carers. This estimates that an anticipated extra spend on carers for England of £293 million would save councils £429 million in replacement care costs and result in “monetised health benefits” of £2.3 bn. This suggests, as a ratio, that each pound spent on supporting carers could save councils £1.47 on replacement care costs and benefit the wider health system by £7.88.[10]

18. The services carers receive and require are diverse and include a wide range of

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[7] https://carers.org/sites/files/carerstrust/related_documents/carerstrustwalesmanifesto.pdf
[8] http://gov.wales/about/cabinet/cabinetstatements/2017/carerfriendlywales/?lang=en
[9] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/carers-support.aspx
[10] Department of Health (2014) Impact Assessment (Carers)
http://www.legislation.gov.uk/ukia/2014/407/pdfs/ukia_20140407_en.pdf

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local and national services. Services include:

- information, advice and support
- short breaks
- replacement care
- palliative care
- employment support
- training
- benefit support.

The preventative value of these services, both in securing the well-being of individuals, and in avoiding additional costs to local authorities and local health boards, is well-established. For example:

A longitudinal study of 100 people with dementia found a 20-fold protective effect of having a co-resident carer when it comes to preventing or delaying residential care admissions[11]

Carers providing more than 50 hours of care per week are twice as likely to report ill health as those not providing care. Wales has the highest proportion of carers providing more than 50 hours of care per week in the UK.[12]

19. One study found that problems associated with the carer contributed to readmission in 62% of cases[13]

20. Additionally, many carers are unaware of the extra financial support they are entitled to. In 2010, a working paper by the Department for Work and Pensions estimated that uptake of Carer's Allowance across the UK was around 65%.[14]

21. Out of carers surveyed, 9% had missed out on Carer's Allowance for 3–5 years, 10% for 5–10 years and 14% for over ten years, because they did not realise they were entitled to it.[15]

Prioritising and funding respite care

22. We know that carers value flexible breaks and respite care. Breaks can help to ensure that the carer remains well and is able to continue to provide care. The Social Services and Well-being (Wales) Act places carers on the same legal

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[11] Banerjee, S, Murray, J, Foley, B, Atkins, L, Schneider, J, Mann, A (2003) Predictors of institutionalisation in people with dementia, *Journal of Neurology, Neurosurgery & Psychiatry 2003*, 74,1315–1316.
[12] http://static.carers.org/files/in-poor-health-carers-uk-report-1674.pdf
[13] Williams, E, Fitton, F (1991) Survey of Carers of elderly patients discharged from hospital, *British Journal of General Practice*, 41, 105 –108.
[14] https://carers.org/sites/files/carerstrust/related_documents/carerstrustwalesmanifesto.pdf
[15] https://carers.org/key-facts-about-carers-and-people-they-care

footing as those they care for, and places a duty on local authorities to promote and provide preventative services.

23. Despite this, services across Wales that provide quality breaks and respite for carers have been squeezed, and commissioning has focused increasingly on price rather than quality. We have also seen a significant decrease in individuals accessing day services or respite care since 2012.[16]

24. We believe that there would be value in introducing a national Carer Well-being Fund to provide additional breaks for carers across Wales, coordinated by the third sector and delivered in partnership with local authorities and local health boards.

25. Introducing a modest fund of approximately £1.4million a year would be able to generate over 53,000 hours of additional breaks for carers in Wales. This relatively small investment would also provide a powerful base upon which third sector preventative services could build and develop. Such a fund would have the long-term benefit of helping mitigate against additional or unsustainable demand on local health and social care services.

To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts arising from the UK leaving the European Union;

26. We know that many unpaid carers could not manage without the high-quality support of paid care support workers. The government must ensure that enough paid staff are available to support carers – wherever these workers come from in the world.

27. Planning for the different scenarios possible after the UK leaves the European Union in March 2019 must be considered. Plans must be put in place to ensure that there is no rapid or sudden decrease in numbers of paid care support workers, as they help many carers get the break from caring that they need, or provide the reassurance to carers that the person they care for is having their needs met. It is vital for the health and wellbeing of unpaid carers to get a break from, or support with, their caring role. It is important that after Brexit, carers still have access to this support from paid care support workers.

To consider the financial impact of current Welsh Government policies - including recent social services legislation and reforms to social care funding - on local authorities, care providers and service users;

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[16] https://carers.org/sites/files/carerstrust/related_documents/carerstrustwalesmanifesto.pdf

28. Funding for Carers services is insufficient, and narrowly restricted to the implementation of the Social Services and Wellbeing Act. It is also short term in nature and lacking in transparency at the point of allocation.

29. Consideration needs to be given to the cost benefit of properly mapping, commissioning and resourcing appropriate services throughout Wales. In particular, as highlighted above, it is important to more sustainably fund respite care and breaks.

30. Further funding is needed for respite and short breaks. This must be ring fenced to Local Authorities, and part of a long-term funding stream. We have been funded by Welsh Government to undertake a Wales wide study to investigate the ways in which flexible support (including emergency support and short breaks) could best be provided longer term. It is important that these report findings are used to deliver a step-change in the funding and commissioning of appropriate respite services for carers across Wales.

31. The challenges facing unpaid carers in Wales today are significant and have growing potential to impact on our public services if they are not robustly addressed. The demand on health and social care services is growing and projected to grow further still. If just a small percentage of carers stopped caring, health and social care services could easily become unsustainable. Supporting our unpaid carers is the definition of a preventative integrated health and social care service.

32. At a national level, in particular within Welsh Government, unpaid carers are largely considered within the parameters of the Social Services and Integration department. Current thinking, and policy development within other departments fails to be fully cognisant of the fact that public services, particularly our NHS, are increasingly being challenged by carer-related issues and will be challenged further still if carer relationships breakdown as a result of lacking support.

33. It is important to address the wider issues facing carers in a way that is mindful of the significant impact failing to support carers could have on the wider economy, health and social care services. There are significant social and economic advantages to supporting carers to live health and fulfilling lives. It is important that policy, legislation and practice work together effectively to deliver a truly carer friendly Wales.

34. We believe that a new Carers Act for Wales could be a key piece of legislation that could usefully bring together many of the unconnected strands of carer support and deliver some much-needed funding. Crucially, legislation would give Wales the opportunity to address some challenges in a clear and definitive way including:

- delivering carers needs assessments
- informing carers about support
- supporting carers in education
- supporting carers in employment
- recognising carers as partners in the care of the person they care for in medical settings

35. Such legislation would build on the legislative progress already made by Welsh Government in social care by delivering more focus and funding to the carers elements of the Social Services and Wellbeing (Wales) Act.

    A similar Act in Scotland is at pre-implementation stage but is already ensuring that the issues are being addressed jointly by different departments across Scottish Government.

    It also includes elements designed to address many of the structural barriers to supporting carers in the longer term which we also face in Wales, such as:

    - a lack of data collection for carers.
    - a lack of identification of carers of all ages in a variety of contexts (including schools and healthcare settings).
    - a lack of self-identification.
    - a lack of information and support.

    A Carers Act for Wales could help to deliver collaboration, joined up thinking and appropriate funding for many of the practical day to day requirements for local authorities in particular: how to fund, train and support delivery and promotion of carers needs assessments.

    A Wales Carers Act would be an opportunity to address the issues in detail for the long term. Delivered properly, it would not only save public services huge sums of money, it would send out an important statement that Welsh Government is addressing and acting on a critical issue for the nation's future.

Additional information

Groups of carers with specific needs

36. It is important that the committee is mindful of some of the specific challenges facing older cares and carers of people with dementia when considering evidence in relation to this inquiry.

Key Issues for Carers of People with Dementia

37. Carers Trust's research into the experiences and needs of carers of people with dementia, demonstrates clearly what the issues faced by this group of carers experience. A Road Less Rocky[17], sets ten key crisis points when carers of people with dementia need specific, information, advice and support in their own right to prepare for and cope with their caring journey. These are:

    - When dementia is diagnosed,
    - When the carer takes on an "active" caring role,
    - When the capacity of the person with dementia declines,
    - When the carer needs emotional support and/or a break from caring,
    - When the person with dementia loses their mobility,
    - When the person with dementia has other health problems,
    - When the carer has to cope with behavioural problems,
    - When the carer's own circumstances change,
    - When the person with dementia becomes incontinent,
    - When decisions about residential care and end of life care have to be made

38. Carers are still going unidentified at an early enough point whereby they reach crisis point at one of these later points which has long term implications for their own health and wellbeing and often leads to the person they care for being admitted to residential care.

39. Carers of people with dementia experience particular challenges that are in addition to the wider issues experienced by all carers. Often due to their age, the nature and complexity of dementia and their own health needs they are a particularly vulnerable group who need attention in their own right.

40. It is important that all hospitals in Wales develop their carer awareness to ensure that carers are included throughout the care pathway which would reduce poor discharge practices.

41. Additionally, Commissioners must ensure carers of people with dementia are included in commissioning decisions including ensuring their own needs (as identified in the Road Less Rocky) are taken into account when commissioning services.

Older carers

42. The numbers of older carers is growing all the time, those aged 85 and over grew by 128% in the last decade (Carers UK and Age UK, 2015).

[17] Newbronner. L, Chamberlain. R et al, A Road Less Rocky – Supporting Carers of People with Dementia, Carers Trust, 2013

43. Older carers have their own specific needs and have tended to be a forgotten group, often going unidentified because they do not recognise themselves as a carer or are not recognised by services. With an aging population and the increase in the life expectancy of people with learning disabilities which is to be celebrated; people are caring for longer and later in their lives[18].

44. Key issues for older carers include:
    - Lack of recognition of their own health needs and the impact of caring on their own health and wellbeing.
    - Isolation and loneliness, especially in relation to unavailable, inappropriate or inaccessible transport.
    - Complex management and navigation models of health and social care systems with no support.
    - Lack of preparation including a lack of awareness of the likelihood for caring in later life, especially so for carers who have been caring for children with long term conditions whose life expectancy meant they were unlikely to reach old age but increasing numbers now are.
    - Older carers have a strong sense of "duty to care", this can be reinforced by health and social care professionals which means they may feel they have no choice or continue to do so longer than they are able.
    - Lack of information on financial planning, including information on lasting powers of attorney are not provided at an early enough point.

    It is also worth referring to a number of reports produced by Carers Trust which support this[19][20]:

To support older carers it is important that:

45. Primary and secondary care services identify older carers as early as possible and ensure they are referred for a carers need assessment.

46. Planning for caring in later life should be considered as a public health priority and the public supported to plan for their own care needs and the potential for becoming a carer in later life.

47. Health and social care systems must be aligned and integrated to ensure older carers are not required to navigate the complex systems for both their own and the person they care for's health needs. This presents particular challenges when discharging an unpaid carer from hospital.

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[18] Marks. L, Retirement on Hold, Carers Trust, 2016 (due to be published January 2017)
[19] Fraser. M, Always on Call, Always Concerned, Carers Trust, 2011
[20] Caring about Older Carers: Providing Support for People Caring in Later Life, Carers Trust, 2015

48. There must be improved information and guidance on financial planning including information on Lasting Powers of Attorney to ensure carers are prepared for the future and are not required to address these issues too late in their caring journey.

49. Public, community and hospital transport must be improved to address issues of isolation and loneliness which are particularly acute issues for older carers.

50. Clearer support and guidance to help carers navigate a complex health and care system.

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

	The Welsh NHS Confederation response to the Finance Committee inquiry into the cost of caring for an ageing population.
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Date:	19 February 2018

Introduction

1. We welcome the opportunity to contribute to the Finance Committee inquiry into the cost of caring for an ageing population.

2. The Welsh NHS Confederation represents the seven Local Health Boards (LHBs) and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

3. As highlighted in our recent briefing, "*Finance and the NHS in Wales*",[i] there is little doubt that health and social care services have faced, and will continue to face, enormous challenges over the coming years with increasing demand and expectations. We have the opportunity in Wales to create a sustainable health and social care system that the Welsh population needs and deserves and the recently published Parliamentary Review of Health and Social Care in Wales report provides us with a renewed urgency for discussion and the framework within which vital decisions for the future of our health and social care system can be taken.

4. The current system was designed nearly seventy years ago when life in Wales was very different than it is today. There is a real need to shift, at pace, the health and social care system in Wales away from treatment to an integrated system based on well-being, prevention and early intervention as set out in the Parliamentary Review report.

5. However, one immediate challenge is the need for appropriate levels of funding and a long-term funding model to support the health and social care system. Without adequate funding and new investment for health and social care in the future, the changes outlined in the Parliamentary Review report will not be enough to ensure a sustainable health and care system.

The Terms of Reference for the inquiry are:
To examine patterns in demand for social care services for those of pension age and the related costs of delivery of residential and non-residential care, taking account of the role of informal carers who provide unpaid services to those requiring care;

6. Since the creation of the NHS almost 70 years ago, society has changed dramatically. Our average life expectancy has improved considerably, which is partly down to the success of the NHS and is something to celebrate. However, an ageing population also brings with it a series of fresh challenges for the health and social care sector, and as with all other UK health systems, the NHS in Wales faces these challenges as it works against a backdrop of increasing demand and under increasing financial pressure.

7. An ageing population, coupled with an increasing number of people having multiple and complex needs, means the demand for health and social care services is predicted to grow rapidly in the near future. Wales has the largest and fastest growing proportion of older people (aged 65 and over) of any other UK nation. The population of older people in Wales grew by 77,176 people between 2009-10 and 2015-16 and formed 20.2% of the population in Wales in 2015. In contrast, older people formed 17.7% of the English population in 2015.

8. The number of people aged 65 and over is projected to increase by 50% by 2037 in Wales while the number of young people aged 16-24 is set to decrease by 3% by the same year.[ii] More than a third of the population of Wales is expected to be over the age of 60 by 2055 and by 2069, those aged over 75 will be the biggest proportion of all age groups.

Wales Population Projections

People Aged:	2016	2020	2025	2030
65-69	195,540	176,970	186,400	207,450
70-74	154,830	179,960	164,790	174,440
75- 79	116,570	132,020	159,990	147,640
80-84	85610	93,160	108,770	133,620
85+	84370	95,430	114,500	141,530
Total	636,920	677,540 +6.37%	734,450 +15.31%	804,680 +26.33%

*% changes are all from 2016

9. In addition to the projected increase in older people, Wales currently has the highest rates of long-term limiting illness in the UK, which is the most expensive aspect of NHS care. Between 2001-02 and 2010-11 the number of people with a chronic or long-term condition in Wales increased from 105,000 to 142,000.[iii] This figure is expected to rise for a number of conditions, including cancer, dementia and diabetes.

10. In relation to residential care, the care home market remains a significant part of the national care and support offer. This is a vital sector with who our members work in partnership and together will consider the future services required to meet the change in demographic. The Welsh Government Care Home Steering Group, established to investigate and report on key issues impacting on the care home sector in Wales, includes Carol Shillabeer, the Chief Executive of Powys Teaching Health Board as a member.

11. While we need to be cautious in planning demand for care home placements based purely upon population projections and current use of care homes because demand, as stated below, will be influenced by a range of factors. We can say however, if everything else stood still the changes in population could lead to the need for additional placements in care homes.

12. According to Care Inspectorate Wales, as at March 2017 there were 642 care homes providing 22,217 places for adults over 65.[iv] Some homes have closed since this time but it is worth highlighting this is about double the average number of daily available NHS beds, which in 2016 – 17 was 10,856.[v] Health Boards and Local Authorities spend approximately £369 million on placements in care homes for older people in Wales. This excludes client contributions, third party payments and the fees paid by those individuals who fund their own care. This is a substantial market and contributes significantly both to the economy and employment in Wales.

13. The care home market for older people is far from being in a state of equilibrium with considerable vacancies in the residential care sector together with difficulties in responding to demand for nursing home placements in some areas at the time they are required. Care homes themselves report serious challenges both in terms of funding and workforce recruitment, retention and development. People are also being admitted with more complex needs. The future demand on places in care homes will be dependent upon a range of factors. These include:
    - The growth of the population of older people;
    - The support available from family and friends;
    - The quality of support available to family/ carers is essential;
    - Effective arrangements for assessment and care planning;
    - The development of the range and quality of care and support services in the community together with alternative accessible forms of accommodation such as, for example, extra care housing;
    - More effective treatment and support to individuals with long term conditions. This also involves treatment and support to help individuals manage problems in relation to continence;
    - Development of technology enabled care to help individuals manage their own care and provide additional safeguards; and
    - The development of appropriate care pathways to ensure that individuals have access to rehabilitation and reablement.

14. Finally, the role of informal carers is key. There are estimated to be more than 370,000 unpaid carers in Wales and the contribution they make is enormous, both in terms of care hours provided, the increasing number of elderly carers and the toll on their own health, well-being, employment and leisure opportunities. Research carried out by Carers UK[vi] found that half of carers (52%) said their health was affected as a result of their caring responsibilities. The amount of care provided by unpaid carers saves the Welsh economy £8.1bn every year.[vii]

15. Within the Welsh Governments Carers Measure 2010, Health Boards were given a lead role to work with partners including Local Authorities, third sector and importantly carers themselves. The Carers Measure has been repealed with the introduction of the Social Services and Well-being Act 2014 in April 2016. The Act provides new rights for carers and identifies integration of services for carers as a priority under part 9 of the Act. As part of the Social Services and Well-being Act, Health Boards have developed Regional Carers Strategies to support carers within their population. One of the biggest challenges in relation to informal carers is the need to access respite provision which is suitable and accessible in the local area. Currently respite provision is very hard to commission as providers do not appear to have much capacity for this.

To examine the financial pressures on the social care system, such as increases in wages, automatic pension enrolment and staff recruitment and retention difficulties, including the related financial impacts arising from the UK leaving the European Union;

16. The Health Foundation report, "*The path to sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31*",[viii] found that in 2014/15 Wales spent £1.2bn on personal social services, excluding family and children's services. This is worth around £397 per head of population, which is higher than in England (£290). Pressures on publicly funded adult social care in Wales are projected to rise by around 4.1% a year in real terms, using estimates from the London School of Economics and Political Science (LSE). Fully funding these pressures would require an extra £1.0bn by 2030/31, rising to £2.3bn from £1.3bn in 2015/16. The steps taken by the NHS to support and work with other services, and by government to adequately resource them, will have implications for the long-term sustainability of the health and social care.

17. The Wales Public Services 2025 report, "*A delicate balance? Health and Social Care spending in Wales*",[ix] highlights that given population and other demand trends, projections suggest there will have to be a near doubling of spending on Local Authority social services for older people by 2030. The report highlights that Wales has pursued a more balanced approach to NHS and social care spending than England over the period 2009-10 to 2015-16, but, even so, spending through Local Authorities on social care for the over 65s is not keeping pace with the growth in the population of older people. The increasing over-65 population in Wales means that spending per older person has fallen by over 12% in real terms over that period and on current population projections, Wales would need to be spending at least an additional £129 million (23%) by 2020-21 (at 2016-

17 prices) to bring the per capita spend on Local Authority social services for over-65s back to 2009-10 levels, which is equivalent to a year-on-year growth rate of 2.5%.

18. It must be recognised that Wales made a distinctive set of choices over its spending on health and social care over the period 2009-10 to 2015-16 in responding to complex challenges. Budgets were squeezed and UK Government austerity measures led to an 8.2% reduction in the funds available for day-to-day spending in Wales at a time when demand pressures grew.

19. An effective interface between health and social care has been crucial in responding to these challenges. Budgets for England have concentrated on increasing health spending while local government spending on social care has declined, whereas in Wales the Welsh Government pursued a more balanced approach. The total health, personal and social service spend per head in Wales was 6.3% higher than that of England in 2015-16, £2,733 compared to £2,571 (2016-17 prices). The day-to-day spending on Local Authority-organised adult social services has remained broadly flat in real terms in Wales, while in England it fell 6.4% over the period 2009 10 to 2015-16.

20. In relation to the care home sector, as the Public Policy Institute for Wales "*The Care Home Market in Wales: Mapping the Sector*",[x] highlights due to the financial pressures it has become more difficult for new entrants to enter the market, particular as capital costs for entry are high. This along with the introduction of the National Living Wage and work place pensions is affecting the financial viability of care homes in Wales.

21. Care homes in Wales, and throughout the UK, are experiencing serious challenges in terms of financial stability, recruitment of staff, including nurses and registered managers, responding to higher levels of acuity and dependency among their residents, including more complex health conditions, and not least the negative image of care homes. "*The Care Home Market*" Report[xi] highlights at the current time there are two particular risks that might need to be considered. Firstly, the potential for a large provider to get into major difficulties leading to the sudden withdrawal of a significant number of services from the market. Although the market share of large providers in Wales is comparatively low, this risk is always a possibility and something which needs to be factored in to any future oversight regime. The second particular risk is of ongoing closures of smaller group and single home providers as the economics of the market make them less viable and sales of property more attractive to their owners. Although a policy goal is to support people in the community wherever possible, the significant number of older people aged 85+ projected suggests that demand for care homes is unlikely to reduce during that time without huge investment in alternative provision such as extra care housing.

22. Finally, in relation to Brexit the implications of a UK withdrawal from the EU are anticipated to affect all parts of the health care system. Many aspects of UK health and social care services have been influenced by European Union policies and legislation. Depending on the settlement, the UK's exit from the EU could have a profound impact on the UK economy and the delivery of public services. The annual funding of the health and

care system depends on the performance of the economy. It is a concern therefore that leading economists have suggested that Brexit could lead to an economic downturn. The Health Foundation has previously estimated that the NHS budget in England could be £2.8 billion lower than currently planned by 2019-20.[xii] In the longer term, the analysis concludes that the NHS funding shortfall could be at least £19 billion by 2030-31– equivalent to £365 million a week – assuming the UK is able to join the European Economic Area. If this is not the case, the shortfall will potentially be as high as £28 billion – which is £540 million a week. The repercussions will be felt by NHS and social care in Wales.

23. In addition to finance, the health and care system is heavily reliant on EU workers. While the UK Government has given some reassurance that EU nationals can remain in the UK, we believe the priority must be to ensure that the UK can continue to recruit and retain much needed health and social care staff from the EU and beyond, whilst increasing the domestic supply. Our priority in NHS Wales will be to ensure a continuing 'pipeline' of staff for the sector. The immigration system that is in place after the UK leaves the EU will need to ensure that, alongside our domestic workforce strategy, it supports the ability of our sector to provide the best care to our communities and people who use our services.

To consider the financial impact of current Welsh Government policies - including recent social services legislation and reforms to social care funding - on local authorities, care providers and service users;

24. From a NHS perspective the financial impact of the Social Services and Well-being Act 2014 and Well-being of Future Generations Act 2015 is still unclear because it is very difficult to quantify the costs but they have led to increased joint working between health and social care and improved outcome for individuals accessing services.

25. Part 9 of the Social Services and Well-being (Wales) Act 2014 ('the Act') puts onto a statutory footing seven Regional Partnership Boards (Boards) which bring together Health Boards, Local Authorities, the third sector and other partners to improve the efficiency and effectiveness of service delivery. The Boards oversee the Integrated Care Fund (ICF) for their region and their purpose is to improve the outcomes and well-being of people in response to the population assessment, also required by the Act. As part of their role in making the best use of resources, Boards are required to promote the use of pooled funds. Pooled funds must be established in relation to care home accommodation functions. Boards must also consider the need for a pooled fund whenever they jointly respond to the population assessment. The NHS highly values the Regional Partnership Boards and across Wales senior joint posts are being created between health and social care.

26. The establishment of the £50 million ICF in 2014-15 has been a key driver for health and social care integration in Wales, focusing initially on enabling older people to maintain their independence at home, avoid unnecessary hospital admission and to prevent delayed discharges. In 2017 the ICF scope was widened to include older people with complex needs and long-term conditions (including dementia), people with learning disabilities, children with complex needs due to disability or illness and carers.

27. The fund has supported collaboration and partnership working across social services, health, housing, the third sector and the independent sector and has built on existing good practice. It has also provided pump-priming money for the development of innovative and new models of service delivery, care and support. Its success comes from providing dedicated resources, joint decision-making and collaborative styles of working to enable public servants to deliver transformational change.

Examples of how ICF Funding has been used across Wales in 2016-17

West Wales: nearly £235,000 was used by the Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT) which aims to improve opportunities for independent living in the community and reduction in social isolation for individuals. The latest figures show 1090 bed days saved and 109 hospital admissions avoided. 100% of recipients surveyed said the service had made things better.

North Wales: nearly £57,000 was used for Occupational Therapy in Wrexham Maelor Hospital and Ysbyty Glan Clwyd to provide a point of contact for families and patients at weekends to expedite supported discharge. Latest figures show this service has supported 138 patients and saved an estimated 60 bed days.

Gwent: nearly £120,000 supported new Patient flow co-ordinators who work to reduce lengths of stay and delayed transfer of care. On average there are 103 patients who are medically fit for transfer and in an acute hospital at the end of each day. This funding aims to reduce this figure by 10%.

Western Bay: funding for a specialised nursing team that has consistently improved hospital admissions avoidance. Last year the service resulted in 70 admissions being avoided.

Powys: £30,000 for the Good Neighbour Scheme, which offers 1:1 befriending support for older people with the aim of providing practical support, reducing isolation and promoting independence. Latest figures show 143 people have used the service (37 new clients in the last quarter) with some 95 volunteers involved.

Cwm Taf: nearly £100,000 for the Complex Discharge Team which supports joined up services between primary care, secondary care, community care, social care and voluntary organisations. To date nearly 200 people have been supported by this scheme.

28. The Public Service Boards (PSBs), introduced as part of the Well-being of Future Generations (Wales) Act 2015, enable public services to commission and plan collaboratively, ensuring services are integrated and that care and support provided improves health and well-being outcomes for the local population. The Population Needs Assessments that have been undertaken will help PSBs to identify priorities and specific

actions they need to meet the health and well-being needs of their citizens and to help tackle health inequalities in their areas. Consideration should be given to involving other partners in the design of local preventative services, including non-devolved public services, local private companies and social movements. By leveraging innovative partnerships, the NHS could find cost-effective and scalable ways to monitor their rising-risk patients, engage more closely with patients and utilise the skills and qualities of local people wherever possible.

29. All partners share a clear vision to transform the way we support individuals, families and communities, adopting a new model of integrated health and social care services. However, finding ways to fund sustainable and cost-effective services is challenging for all sectors. Development of new delivery mechanisms such as social enterprises and encouraging people to take more responsibility for their own health and well-being is not a panacea for all needs. By providing more preventative and early intervention services, we can support people as soon as they need it, help them to remain happily within their family and community, and for some, avoid expensive and disruptive specialist and substitute care. By doing this successfully over time we can take some resources out of specialist and substitute care and into better community and universal services. However, there will still always be a need for some specialist care and a more innovative and sustainable solution is needed.

To consider future social care needs and related costs, including the projected increase in the proportion of the population of Wales of pension age;

30. As highlighted previously, finance has long been a challenge for health and social services, but never more so than since the economic crash nearly a decade ago. Since then, all public services have struggled in the face of public finance austerity and while the NHS and social care have been relatively protected in Wales (compared to England and other Welsh public services), both sectors continue to struggle in the face of an ageing population with increasing chronic and complex health conditions.

31. Such a rise in demand, coupled with constrained financial resources, has made delivering health and care services in the current model increasingly difficult. The NHS is committed to working more efficiently to rise to the challenges it faces. However, it has become increasingly clear that traditional methods of savings are unlikely to deliver what is needed. It is important that we are realistic about the current and future costs of health and care services and we need to work with stakeholders across the health and care sector to fully understand the future resources required to secure the system.

32. Core NHS spending now accounts for more than 50% of the Welsh Government's revenue budget. However, in line with the rest of the UK funding growth, it has not kept pace with the overall growth in Gross Domestic Product – something which the Health Foundation[xiii] suggests is key to ensuring a sustainable NHS in the future. At the same time social care spending on day to day adult social services has remained broadly flat, but the increasing over 65 population in Wales means that spending per older person has fallen by nearly 13% in real terms over that period.

33. The public finance outlook for the foreseeable future at least remains pessimistic and the indications are that the growth in funding which is badly needed in both health and social care will be very difficult to find and will require difficult choices to be made about public services in Wales.

34. The Health Foundation report,[xiv] referred to earlier, articulated the financial challenge facing the health and social care sector in Wales over the next fifteen years. The report suggests that a sustainable publicly financed healthcare system in Wales is achievable by 2031, but only with growth in funding in line with growth in GDP in respect of the NHS, plus a 4% uplift year on year in social care funding. The Institute for Public Policy Research[xv] estimates that across the UK there will be a funding gap to the tune of £13 billion for adult social care, equivalent to 62% of the total expected budget, by 2030-31 and they warn "*on current trends, adult social care is unsustainable*". Many other public services have been squeezed out as Councils essentially run social care and school provision. Unless funding for adult social care rises at the same rate as pressures, or there is a dramatic change in the rate of efficiency growth for social care services, there is a risk that the level of unmet need in Wales would rise.

35. Both the NHS and Local Government have delivered millions of pounds of recurrent efficiency savings over the past five years, as evidenced in various Wales Audit Office reports.[xvi] We now need to become more sophisticated in our search for further resource releasing efficiencies, going beyond the delivery of traditional technical efficiencies to consider the efficiency of our resource allocation, based on a better understanding of the outcomes of our spending decisions. As highlighted within the Parliamentary Review, there is further potential to drive technical efficiencies from across the NHS. Our members are working to implement an efficiency programme using benchmark data, but we believe a greater pace could be achieved if Wales adopted a more systematic approach to efficiency, akin to the Carter work in England.[xvii] Similarly, we urge Welsh Government, Health Boards and Councils to consider the allocative efficiency of their budget processes to ensure they allocate resources to support a preventative model of health and social care.

36. Even then, the demographic trajectory combined with medical and pharmaceutical developments will lead the health and social care sector to continue to need substantial ongoing financial support, which is likely to involve further disinvestment in other public services. We recognise that the funding required is not within the Welsh Government's gift, even with the introduction of income tax raising powers. But we cannot simply ignore the reality of the problem.

37. Many public-sector leaders – politicians and policy makers – already recognise that the current funding model is no longer fit for purpose. It was designed in the post-war era when the birth rate was falling and the world was a very different place. While we would all champion a free health and social care system for all, those in positions of responsibility need to be honest with the public about what that could mean in the future. Especially if

we don't succeed in securing the shared ownership and changed behaviours from the public.

38. We believe that it is not possible to consider the long-term future of health and social care in Wales without considering the issue of how and to what level the system should be funded in the future as this will impact on decisions we make in the next five to ten years. Short term funding fixes will not suffice if we are to address the serious financial challenges we face. Neither will small scale amendments to the edges of service delivery. Indeed, the recent House of Lords Select Committee report into the long term sustainability of the NHS calls for radical service transformation, long-term funding solutions and immediate and sustained action on adult social care as the three key objectives that must be addressed if the NHS is to make real progress towards achieving long term sustainability.[xviii] We agree and believe that governments need to consider alternative funding models for the health and social care sector in the future. This could include options such as increasing taxes as well as paying for specific services or rationing others.

39. Finally, health and care providers need to work with education colleagues to ensure that schools and colleges highlight that a career in caring is a positive career choice. Failure to do so will mean less and less young people entering this field of work and the inability to provide care for those who need to receive it. The NHS has already started working in a more coordinated way with our education colleagues, including an event in Cwm Taf UHB where Year 9 were invited into Prince Charles Hospital, Merthyr, to show them the breadth of work undertaken by the NHS to provide 24/7 care and to inspire them to consider a future career within the service.

To assess the fiscal levers available to the Welsh Government to reform the arrangements for funding social care. This will include the consideration of alternative models, including international examples, for the funding of social care to ensure a good quality, fair and sustainable service in a time of increasing demands on the health and social care systems;

40. Some commentators are arguing that we now need a dedicated national health and care fund for integrated health and care. This would require some general taxation but could be gradually built up with more money from hypothecated taxes associated with health and consumption of care. This means using taxes on tobacco, alcohol, unhealthy foods, gambling and inheritance, and possibly a compulsory insurance tax at age 50, to pay for social care in old age. At its 2014 conference the Royal College of Nurses nationally debated whether a possible solution to current challenges would be to introduce patient charges for GP visits. Others have suggested that well-designed user charges would not only raise additional revenue, but would also limit unnecessary demand, encourage greater cost-effectiveness in the use of healthcare services, and promote the adoption of healthy lifestyles.

41. In addition to fiscal levers available to the Welsh Government, to ensure a sustainable health and social care system it is vital that we empower the public to become active

participants in the services that they receive. Changing public attitudes and behaviour is critical, as the Parliamentary Review highlighted we need to put the people in control through "*Strengthen individual and community involvement, through voice and control in health and care, and ensuring all ages and communities have equal involvement*".

42. There is an urgent need for a meaningful dialogue with the public about the future of public services, their expectations of these services and the different role they need to play. This is vital because evidence shows that public support is critical to delivering and securing policy and behaviour change. Programmes that are most successful in galvanising public support are those which place the public at the heart of the decision-making process, particularly when combined, where appropriate, with enabling legislation. This is borne out by successful national policies and programmes, such as seatbelt laws, the carrier bag levy, road safety campaigns, banning smoking in public places, and most recently in Wales, organ donation. In Wales we now have the legislative framework we need in the form of the Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014, but we still need to win the hearts and minds of the Welsh public.

43. Currently, the Welsh public is being bombarded with messages from public services, voluntary organisations, government, various media outlets and personal networks. Similarly, there are different requirements around public consultation in health and social care. There is an opportunity for effective communication and engagement with the public and patients to be more impactful across the whole public service by developing holistic messaging which would encourage public acceptance of the need for change.

44. There is also a requirement for an open and honest conversation with the public about what the NHS can provide in future. While the NHS is free at the point of contact, it is not free of obligation, and the public will need to be supported in taking more responsibility for their own health. The NHS belongs to us all, and as individuals, we should do what we can to ensure it is sustainable, both now and in the future. In January 2017, the Welsh NHS Confederation conducted a survey[xix] which provided some encouraging results around the public's understanding of their role in taking responsibility for their health well-being and a willingness to take action. More than 90% said they have a great deal or a fair amount of responsibility for their own health and well-being, while 55% said they should be doing more to look after their own health and well-being.

45. These ideas may be controversial, but shying away from difficult debates over these issues will not help the health service or social care an in the long run.

To consider the findings and conclusions of the Parliamentary Review.

46. The Welsh NHS Confederation welcomed the publication of the Parliamentary Review Report and are pleased to see many of the points raised in the report reflect the evidence submitted by the Welsh NHS Confederation as part of the consultation process, including a number of recommendations that we put forward.

47. The report makes a major contribution to the debate on how to create a sustainable health and care system in Wales. Our members agree that a different system of care is needed – one that is seamless across health and social care, physical and mental health, and secondary and primary community care.

48. The report recognises that we have been moving towards a more integrated system for a number of years and there are many good examples of new models of care that are already working in Wales. The challenge is how we can be more radical and ambitious, to accelerate the pace in moving to a genuinely seamless system. We are particularly pleased the report recognises the need to involve the public in the design and development of new service models. The citizen voice must be part of the solution to the challenges we face, with people being empowered to be actively involved in their own health and wellbeing.

49. While supportive of the Parliamentary Review findings, the report raises concerns around funding of health and social care in the future. The absence of any consideration of the long-term model for funding health and social care is the elephant in the room. We agree it is crucial for us to increase the value we achieve from the funding of health and care. It is also helpful that the report recognises that the level and sources of funding for health and social care remain key national issues. As we develop plans to transform the health and care system we must ensure they are supported by sustainable funding. We have recommended that the report is considered in conjunction with the Health Foundation's 2016 "*Path to Sustainability*" report that analyses the demand and cost pressures facing Wales now and until 2031. Without adequate funding for health and social care in the future, the changes outlined in the report will not be enough to ensure a sustainable health and care system. As the Health Foundation report states "*There is a strong link between spending on social care and the NHS, so any increase in unmet need for social care would be likely to lead to a rise in demand for NHS services*".

50. Following the Parliamentary Review report we look forward to working with the Welsh Government and other organisations in the health and social care sector to develop a plan of action that will deliver the best services to the people of Wales.

Conclusion

51. The complex nature of finances in the Welsh healthcare system, coupled with various external pressures and challenges it faces, indicates that the growth in funding and the more prudent use of existing resources is needed in health and social care. However, this will be very difficult to find and will require difficult choices to be made about public services in Wales.

52. The NHS and Local Government have delivered millions of pounds of recurrent efficiency savings over the past five years, we now need to become more sophisticated in our search for further resource releasing efficiencies. We need to go beyond the delivery of traditional technical efficiencies to think innovatively and consider the efficiency of our

resource allocation, based on a better understanding of the outcomes of spending decisions.

53. To address the challenges, there is a need for radical service transformation, long-term funding solutions and sustained action on social care if the NHS is to make real progress towards achieving long term sustainability.

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[xviii] House of Lords Select Committee, 'The Long-term Sustainability of the NHS and Adult Social Care', 5th April 2017, HL Paper 151.
[xix] http://www.nhsconfed.org/media-centre/2017/02/whole-system-shift-towards-preventative-services-needed