Association of Directors of Adult Social Services

Response to the Dilnot Commission on the Future Funding of Adult Care & Support (January 2011)

Introduction:

Our Association is a charity encompassing the professional leadership of statutory adult social services in England. Our members are serving or retired local government directors covering the one hundred and fifty two English Local Authorities. We serve councils of all political persuasions. Our contracts proscribe us from political activity and we are politically non-aligned.

Our statutory responsibilities involve formulating and discharging Councils' statutory responsibilities for the commissioning and provision of state funded adult social care services (but many of our members also hold council responsibilities for leisure, housing and community safety responsibilities, and increasingly children's social care responsibilities) and work in close partnership with local NHS commissioners and providers.

In this role we are charged with the responsibility of dispensing the £15billion of public funds allocated to deliver adult social care services. The departments we lead are the point of access to social care for citizens seeking state support to meet their social care needs. Our staff assessments of citizens' circumstances lead to determinations of eligibility for services and whether citizens qualify to make financial contributions to the costs of their care provision. Following assessments support plans are developed for citizens' deemed eligible for support. We are reforming our systems so that through personalisation and personal budgets citizens can exercise greater choice and control over their care support arrangements. We commission services mostly from independent sector and civil society suppliers but also from council run services.

These roles and responsibilities place Directors of Adult Social Care at the very heart of making any reformed system work, and ADASS is highly committed to work with the Commission to secure critically important lasting and sustainable reforms.

Our perspective on the future funding of Adult Social Care

Our role and experience qualifies us to state the requirements which will characterise a sustainable funding settlement and the outcomes it must address. These will inform the evaluation and selection of the options under consideration. We are neither economists nor actuaries and therefore will not

comment on the technical evaluation of the various funding systems. We will comment, from our professional perspective on the impact of various options (as they have been described and evaluated) upon the adult social care system and its beneficiaries.

Please note, we have included a second appendix capturing specific responses from the ADASS Continuing Care Reference Group. These additional comments provide further evidence relating the impact of the various options upon this specific group, particularly in recognition of the potential high costs this cohort represents and the complexities in confirming funding accountability (estimated costs of meeting CHC needs in the current financial year is over £2bn).

We take as given that the current funding system is unsustainable and have contributed with many others across the sector to a proven case for change. This is not repeated here, as it has been well described elsewhere. We welcome the establishment of the Commission and its approach to this task. However, we would contend this must be the last such exercise in nearly fifteen years of deliberation.

We restate with increased urgency our call for a final determination and action to institute a new and sustainable funding settlement. Our daily experience of the pressures in the care system in the face of demographic, technical, workforce changes and more recently severe resource constraints reinforces deepening concerns for the ever growing impact this is having on individuals, families, communities and the staff in the many providers who deliver care and support. Not only can we literally no longer afford to continue with the status quo, but it is wholly reprehensible to leave unaddressed this increasing impact upon affected individuals and their carers.

As with other key strategic issues with long term impacts upon our children and our grandchildren (such as tackling climate change), governments and citizens must not shirk their responsibilities and avoid the tough decisions to address the profound societal impacts of an ageing society, including making a sustainable settlement for funding care and support. The public do not deserve and will not tolerate short term, partial, partisan and ideological positions in any political or media discourse on this matter designed for cynical commercial or political advantage.

Our primary concern, given the experience of the past, is that this will remain in the “too difficult to fix” box and action will either be delayed or not taken at all. This we recognise will be in the hands of the government and to some extent the public, media and other political parties who will shape the conditions in which they make their decisions. However, any action that is constrained will fall far short of a sustainable settlement.

Therefore, we commend and support the stance of the Commission to arrive at and recommend a sustainable settlement, as this is vital to the future capability to care for and support citizens and their families who struggle to do the ordinary activities of daily living that the rest of us can do without a second

thought. Where the Commission concludes that any component is necessary to make this settlement sustainable it should be included in its recommendations regardless of any previous positions that may have been asserted in relation to it.

Question 1: Do you agree with the commission's description of the main challenges and opportunities for the future funding of care and support?

The description of the challenges and opportunities are readily recognisable to our members. Our comments in this section seek to highlight areas where we are concerned that sufficient regard is given.

1.1 Certain prevalence factors must inform distributive mechanisms in any system: these include access to or absence of support from family carers; concentrations in localities of various conditions e.g. mental ill health; material cost variables e.g. staffing, capital recharges or transport costs in various regions; age profiles which reflect higher proportions of people 85 plus where greater needs will be experienced; home ownership and other wealth distributions. Close attention must be taken to ensure that all the material variations are identified and included in any resource allocation formulae for private or public insurance.

1.2 Any change of funding mechanisms to distribute state money to eligible groups will have implications for local government finance given the current distributive formulae. The implications of these need further consideration with the Local Government Group, CIPFA and the Society of County Treasurers. We assume that the Commission has been advised of the review of the basis of current distributive formulae determining the level of funding for adult social care in local government settlement. There is a consensus that they are currently deemed not fit for purpose but there are substantial differences about what weighting should be applied to which factors. A considerable influence on these deliberations will be the impact on resource allocations given the highly constrained resource levels.

1.3 The financial impacts of demographic pressures in older people's cohorts are more fully understood and future trends can be predicted. The greatest concerns in our sector at the present time relate to the financial impacts associated with greater numbers and increased life expectancy of people with learning disabilities. Given the higher and life time costs experienced by this group, there are major pressures where it is not as easy to arrive at reliable forecasts.

1.4 Boundary/interfaces which are confusing for the public and which carry an unnecessary transactional burden must be tackled. In the examples we give below these drive very specific funding responsibilities,

constraints and prescriptive measures. They are often confusing for professionals and impenetrable for the public. They regularly involve formal and informal dispute mechanisms including legal disputes. These factors cannot persist or be imported into any new funding settlement if it is to be fair, comprehensible and easily accessible. This applies particularly to NHS payments for nursing care, NHS Continuing Healthcare (see appendix 2- Response from ADASS Continuing Care Reference Group), some regulatory regimes which threaten supported housing schemes with registration as residential care homes; the different regimes for funding after care and support for mental health service users and some technical residence issues. In some of these instances this will require legislative change and some interaction with the work of the Law Commission, due to publish in the summer. We would question whether this should be delayed to take any account and include in its own deliberations, matters which the Commission itself might deem to be material to the characteristics of the new funding settlement it will recommend. We suggest that the Commission should discuss this with the Department of Health.

1.5 Indubitably in this sector, there is a direct correlation between quality and the recruitment, retention and training and development of the workforce delivering care and support. This is in every sense of the word, a people business. Sustainability is as much about the quality of the service which users will experience. Indeed from the users' perspective this is likely to be the touchstone of sustainability in the system. It is so easily compromised by regular staff turnover where conditions are such that staff cannot be retained. It is a challenge to train and develop a workforce which is deployed in meeting care and support needs. Just making time and affording the cover that will enable this is difficult. Arriving at a sustainable position such that a workforce can be retained and its competence developed to meet the quality requirements and the shifts to emerging better practice and new interventions, has to be given sufficient weight alongside achieving affordability and value for money. Many would argue that currently this is not sufficiently weighted in the existing system and quality is under threat, arguing that more emphasis must be given in any new settlement and would caution building models on the existing costs, given this concern.

Question 2: Do you agree with the Commission's description of the strengths and weaknesses in the current system? Are there any gaps?

We recognise much that is valid in the description provided by the Commission and the points that we outline below indicate where we would place emphasis or add to the analysis.

2.1 As in previous debates, there is concern to get the correct balance between sufficient national standardisation (necessary for transparency and greater fairness) and local variation and discretion to meet relevant local factors (regional cost variations – i.e. rural and urban distribution

patterns) as well as to be accountable/ responsive to local democracy. ADASS commented on this issue in its response to the Green Paper consultations (ADASS response to Green Paper Nov 2009) and will not repeat those points here, as we understand the Commission is taking account of earlier messages.

2.2 However, it is vital to note the "perverse incentives" in prior national entitlement schemes (DHSS payments for residential care; Housing Benefit entitlements to additional payments for vulnerability; Independent Living Fund) have all resulted in demand exceeding resources and substantially increasing national budgetary pressures. In essence, national schemes struggle to exercise controls and validate claims as appropriate to need and tailored efficiently to local supply costs. As a result in each instance, the entitlement has been replaced with a fixed grant which the Local Authority has been charged to dispense (Community Care Case Management; Supporting People Grant and we await the final determination of the ILF). This has been successful in containing significant expenditure growth patterns.

2.3 The substantial strength of the current system is that the same Local Authority is responsible for the allocation of resources to recipients, the assessment of their needs and the commissioning of the supply chain that will provide services. It can balance needs within available resources and address the costs through the service models it commissions and its price negotiations to leverage more direct support provision. Within an organisation responsible for balancing the care budget, assessors are more mindful of resource constraints than when they are supporting applicants in bids to external funding sources. Similarly, suppliers feel the force of these constraints and have to contain costs and margins to compete. National schemes with tariffs (even regionally adjusted) will lose some of this force and risk having applications from assessors or brokers that seek to maximise the level of the award and/or removes the incentive for suppliers to innovate to reduce costs and price, and instead designing to the set price (c.f. the private landlord sector setting rent to the set positions determined by the regional rent officers).

2.4 The position to be squared here is the reconciliation of principles of both fairness and transparency with that of achieving optimal value for money. More national standardisation achieves the former, but compromises the latter. There is no easy resolution of this tension, but we would argue that any new system affecting linkages must be maintained by those with funding, assessment, commissioning and procurement functions and responsibilities. If these are not maintained within single organisations, then other means must be found to establish them.

2.5 Any separate social or private insurance organisation will need to address the access and assessment arrangements which will arrive at the care plan to be funded. One possibility is that they may wish to pay Local Authorities (or franchise some Local Authorities or emerging social enterprises) they assess as meeting their requirements to undertake this

role so that a single common entry point may be established for self and public funded citizens. This could align with any proposals that a period of rehabilitation (re-ablement – currently arranged at six weeks) is offered or required for both self and public funders free of charge. This would be similar to some of the positions in the United States, where the federal funds support all citizens, regardless of means, for a given period (often 100 days). This would meet a gap for self funders who currently are not supported by any available or assured brokerage arrangement, leaving them to haphazardly navigate entry into the care systems. This leaves them making decisions with significant long term personal and financial consequences from an unsupported and inadequately informed position. This risks more costly interventions being selected too early, which in turn will drive up insurance costs as sub optimal elections are pursued. A period of free care/support for everyone would provide time for a more informed assessment of options, creating a more viable and acceptable care plan and one which insurance funds can be assured is best value and mitigates and reduces risks contributing to overall affordability.

2.6 In this regard, it is interesting to note the pivotal role that professional case managers (often nurses) play in the United States' health insurance schemes (such as Kaiser Permanente), in fulfilling a very similar proactive role to steer care plans to preventative and home support options to fit commissioning models (Kaiser Permanente has determined the optimal to meeting need). This approach is supported to a degree by those promoting System Thinking who criticise re-engineering of access systems that see assessments being handled by less qualified people for cost reduction purposes. They argue this results in high levels of demand failure. The argument is that demand at point of access should be triaged by higher paid professionals to avoid this. Avoiding the unnecessary or early use of more costly interventions is essential to making insurance more affordable to many and to making a viable commercial business. Granted that there will be differing positions to be explored, nevertheless this underlines the principle that the effectiveness of the service model deployed is a vital component in the future affordability of public and privately supported insurance, as it mitigates the risks of higher volumes of more costly support when more effective and cheaper alternatives are available.

2.7 Therefore, it is acknowledged that the variations in localities summed up in the phrase "the postcode lottery" have been identified as a primary public concern which must be addressed, although it is recognised that elements of this is an expression of local democracy. The work done two years ago by John Bolton and his team at the Department of Health on the use of resources in social care confirmed that the variation in commissioning models and price variations for similar services is unsupportable going forward. If a local system is going to be maintained, then a programme where all arrive in the same place occupied by the top quartile over a given period is necessary. This will include some regional collaborative/co-operative hubs to negotiate competitive rates applying

across the region (which could act with, and for citizens with personal budgets).

2.8 In terms of tackling confusing and unfair variation across the arrangements in localities, we are engaged with the Local Government Group in strengthening Sector-led Improvement programmes. There is now an urgency to tackle the positions where continued poorer commissioning persists, resulting in much higher reliance on residential and nursing care and where reforms and preventative and re-ablement functions remain underdeveloped compared to others. The main challenge the sector faces is how progress can be accelerated, such that the sector achieves the position of the upper quartile. However, it must be acknowledged that the intensifying resource constraint further undermines limited and weaker capabilities.

2.9 It is envisaged that any new system will set challenging parameters and timescales, supported by incentives and penalties, to deliver what is known to be most effective in prevention and meeting of need at optimal value of money. In other sectors, the funding authorities would set milestones to arrive at the required level of performance and if these are not achieved would seek alternative providers with proven track records. Thus it could be envisaged this would be applied as much to the assessment, commissioning and procurement functions of councils which could be transferred to authorities who have the requisite track record and who could exercise this on behalf of more than one authority. The system will need to invest in developments such as described in the PACE development in the United States and Danish models of provision, and explore their possibilities for creating community based programmes to universalise preventative interventions. This point raises the question of how the necessary capability and leadership capacities can be further developed across the sector.

2.10 In establishing robust and effective social or private insurance arrangements, we would emphasise how critical it will be to find assurance mechanisms to give the public confidence in both the financial and other advisors who may inform or broker their plans. This is particularly the case as confidence in financial services and advisors is still recovering and very fragile, given repeated convulsions in this sector. A robust commissioning and assurance scheme which is transparent must be developed. Anything less risks participation and intensifies significant levels of resistance. ADASS perceives this as a substantial threat to the sustainability of the system.

2.11 It follows from this that insurance providers entering this sector must have a more developed understanding of an effective system and its costs and benefits. At present there is a preoccupation with modelling products around the risks associated with residential and nursing care home provision. These are amongst the highest costs and therefore threaten affordability. More importantly, as has been pointed out previously, this presents an insurmountable marketing challenge which threatens at the

outset prospects for wide take up. We endorse the positions coming from within this sector that argue that marketing must be focused on how to plan and act to live well in old age and how, where support is required, recovery and rehabilitation can be secured or, where this has limited success, means can be deployed to sustain as much independence at home for as long as possible. The current insurance sector must do much more to develop an understanding of customer aspirations and what works in meeting these, so that these align with the best commissioning models locally and internationally. In that sense, they must also play a substantive role in market making and not just endorse or seek to fund existing products in the markets uncritically.

2.12 The issue of how young people with disabilities manage the transition into "adult services" is very fraught for many families, and most councils find it also challenging, despite the considerable effort to make this a satisfactory experience for all concerned. The advent of personal budgets is assisting in giving families welcomed influence over arrangements. However, the key issue remains the significantly different resource allocations given the absence of the whole provision that comes with fulltime education, especially if this has had additional specialist or residential elements. This is a remaining significant weakness. Substantive additional resources are not a realistic prospect, particularly given the very substantial growth pressures in services to adults with learning disabilities. There is at times, a tension as we attempt to enable younger disabled adults to achieve greater independence and more participation in mainstream activities of their peers, where as previously within "children services" they have been supported within specialised environments. This necessitates enabling some risk taking whilst providing assurances that this be managed safely. It is not clear at this time, how the propositions for the funding system can best address some of these factors and will require further work. However, the principles of advanced planning around the options would be a good starting point for further work in this area.

Question 3: What are your suggestions for the reform of funding for care? How do your suggestions perform against the set criteria? How would they impact upon different groups?

In response to the propositions described by the Commission, ADASS would emphasise the following points:-

3.1 The approach articulated by James Lloyd in the paper, "Vision for Adult Social Care Funding" (Vision for Adult Social Care Funding) has much to commend it to complement and inform the evaluative framework the Commission is building. ADASS would support most of the suggestions in that framework. In particular, any system to be assured as sustainable must result in sufficient resources to meet identifiable needs and generate the required additional resources in response to demographic growth.

3.2 We also support the position that it must promote an effective and efficient service which includes encouraging integration particularly with health, but also with specialist supported housing. This would provide clear incentives for interventions progressing prevention and rehabilitation. In contention with the Lloyd paper we believe that the new system must encourage a preference for support in the home where needs can be adequately and safely met there in an affordable way. This is driven as much by meeting aspirations of citizens as of reducing transactional complications and costs relating to “hotel and accommodation costs” and dealing with challenges in the existing system that these set up.

3.3 We urge that serious note is taken of the fact that the most concerted and advanced attempts to deal with this issue in Japan, Germany and the Netherlands (as well as the system that applies in the United States) have not gone far enough and are facing deficits, increases in contributions, increased state funding or individual top ups, rationing and waiting lists. This reinforces the necessity for an accurate basis to establish an adequate level of funding and mechanisms to predict future growth trends in needs and costs.

3.4 We would suggest consideration for the proposition that the Office of Budget Responsibility and the Office of National Statistics be tasked with commissioning actuarial analysis to track trends of growth in older and younger people (particularly adults with learning disabilities) to inform government funding forecasts and present national growth requirements. Their work must address the gap in information to quantify the trends in self funders requiring support and predict their future requirement or entitlement for state support should their circumstances exhaust their means. We know that there is significant unmet need in the current system but this is not quantifiable. This is often demonstrated in crises and breakdowns when carers are not longer able to continue. These would be essential components to inform the Comprehensive Spending Review cycles.

3.5 Whilst we appreciate the various concerns regarding compulsory or mandatory approaches, the recommended system must achieve wide coverage to secure sustainability. We urge serious note of the experience in the United States, where relying exclusively on voluntary private insurance schemes has resulted in a very low take up, contributing only a fraction of the necessary funds. Substantial resources are still required from personal and Federal funds. This leaves the United States confronting much the same issues as the Commission is seeking to solve.

3.6 The Government has recently introduced a change to pension planning, which applies the principle of automatic enrolment with rights to opt out. The principles applying to all aspects of life in retirement should be aligned and therefore automatic enrolment as a default position must be given serious consideration. It is difficult to see how any private insurance proposition can be commercially viable and affordable, unless widespread

enrolment and coverage is achieved (as occurs in motor and home insurance markets).

3.7 In order to achieve affordability and encourage wider coverage, we would support the proposition that the state funds circumstances requiring exceptional well above average costs, or where circumstances will persist over an exceptional period. One example would be the growing numbers of people who have dementia, which people may live with for as much as 12 years. There are very high costs associated with this kind of long term condition, sometimes referred to as the “dementia tax”. The care associated with these conditions could be free to all citizens, or set a very high means test threshold. This will give particular assurance to adults with physical and learning disabilities that have complex conditions with multiple needs and to their families. This would also give similar assurance to those with long term mental illnesses and younger adults who acquire through accident or illness, life limiting complex conditions (e.g. early onset dementia or quadriplegia following an accident). There are current precedents for such an approach most notably in the provision of free NHS Continuing Healthcare. (see attached appendix 2 –Response from ADASS Continuing Care Reference Group)

3.8 Again to secure widespread participation by those of all income groups required to make their own provision for care, it is important that the system is designed to offer a range of options to take account of differentials in income and wealth. These options could include regular premia payments; one off payments deploying retirement annuities or other single large payments drawn from large single events such as inheritance and redundancy payments. However, we contend that the system must include the options to release equity from homes owned and deferred payments where a charge is made on estates. This is already a valued option in some Local Authorities, which enables citizens to avoid the premature sale of their homes. We regret the characterisation of these options in the media as a “death tax”. We envisage that some people may wish to pay for insurance which would cover the average domiciliary costs they may face and, when faced by the added costs of nursing home care, they would elect to pay for this from an equity release scheme or deferred payment. We assert that these are legitimate choices and trade offs, which must be left to people to make in the light of their financial and other circumstances and governments should not interfere by proscribing any such options. It is also clear that we currently have a one generational issue where wealth has been accumulated by older people. Proposals for a future system need to address this temporary anomaly, with perhaps a transitional position as part of a fixed, longer term solution.

3.9 However, it must be noted that there are some Local Authorities where deferred payments may be taken up in significant numbers, such as in larger cities or counties, and these Local Authorities will not have the resources to enable such an option. Therefore, it is suggested that consideration is given to establishing a mechanism such as that which has been set up to manage student loans. Any one of a number of private or

public organisations (including Local Authorities) could be commissioned to run such a facility. Whoever does must be commissioned to maintain low fees and interest rates (more possible through a Local Authority with preferential lending rates). We believe this is critical, as this is likely to be an attractive option to many citizens with comparatively lower incomes and wealth, and they would be discouraged by high fees and interest rates, as is experienced with some current equity release schemes.

3.10 Serious account must be taken of the previous and current loss of confidence in financial institutions and financial advisory services. This will be a barrier to the take-up of the emerging products and restrict coverage and affordability. Therefore, it is suggested that consideration is given, in the first instance, to establishing a not for profit social insurance scheme to build confidence in the system. Those with the relevant commercial expertise could be engaged in the design and management of such a scheme but for agreed and capped management fees. This could be a franchise which is awarded for ten years before it becomes open to market testing. Whilst we believe serious consideration must be given to the points we make in regard to the current local system managed through Local Authorities an alternative possibility is that the government pays in contributions on behalf of those lacking means to make their own contributions. All self and state funded alike would receive personal care budgets for their personal support plans diminishing the distinctions in the market between these two cohorts (though there will always be the possibility that those with means will top up to receive premium care services). If this state and private pooling of resources in a single fund will assist in keeping costs low and making these arrangements more affordable to citizen and state then this is worthy of consideration.

3.11 The Government would commission a framework agreement or let a contract or franchise for the design of care insurance provision and provision of retirement and care planning advice, including financial advice. In the light of our comments above about the links to assessment and commissioning of suppliers, attention must be given to how these functions interact virtuously with allocating of funds if necessary controls and full value for money in the whole systems are to be effectively established.

3.12 Staying with the imperative to encourage widespread coverage, serious consideration must be given to the use of tax concessions, including the enhancement of tax allowances (as is done in gift aid voluntary giving). There are at least two sets of circumstances where this might be applied:

- Citizens who pay in higher premiums to cover high level of risks (such as covering risks relating to both domiciliary care followed by access to nursing home care). This might be equated to those who take comprehensive motor insurance compared to those who pay for third party cover. This could be further incentivised by an agreed percentage payback to estates if circumstances are such that these higher levels of support were not in fact required, thereby adding a

savings element to the plan. Alternatively, some measure of inheritance tax relief might be offered.

- Such measures could also be applied to carers who are undertaking substantially greater than average levels of informal care and support, though this would be of limited benefit in low income households with limited wealth.

3.13 There is a possible trade off here if as is anticipated some current universal benefits (but not Disability Living Allowance) that apply mostly to older people, need to be more targeted. Tax concessions as described above could be offset by the reduction in the level of universal benefits, as these are more targeted.

3.14 It is vital that all is done to continue to secure and indeed, increase the levels of support from family and other informal carers. Any perverse incentives in the system which reduce the levels of this support will only add more substantial cost pressures in the system. It is suggested that serious consideration is given to building on Attendance Allowances for carers and applying personal budgets for carers. Consultation with carers organisations to arrive at a credible respite care allowance (building on the higher and lower rate of Attendance Allowances e.g. on basis of £10/12 per day = £3650/4400 and £5/6per day at £1825/2200 to be managed as a personal budget to deliver an agreed respite care plan). Once again, any increased costs incurred in this support could be offset from the targeting of universal benefits, given the evidence that this is paid to households where no informal support is actually provided.

3.15 In order to make the system more affordable to the public and to private contributors, support must continue for the further development of a more cost effective social care system as envisaged in the Think Local, Act Personal agreement (Think Local Act Personal - Jan 2011) These reforms include key interventions which demonstrably prevent, mitigate and rehabilitate, deploy new technological opportunities and continue to embed personal control and choice. The system must incentivise such features so that demand and costs are effectively reduced.

3.16 This cannot be achieved solely by concentrating on social care. It requires a much greater attention to the integration imperatives in the reforms which remain patchy at best. The contributions of primary and community health to effective community care which will support more people to remain at home for longer. If this is to be embedded, then effective mechanisms in the NHS to transfer investment from acute settings to primary and community health is critical (note in this regard the POPPS evidence that successful preventative interventions are producing savings which accrue mostly to acute hospital care). In this regard, please note our comments related to this matter made under the previous question.

3.17 Inevitably this must take account of the established and emergent work on risk identification and stratification, to inform proactive interventions

with people identified to be at high risk of requiring more costly and long term interventions. In this regard, as with no claims discounts in motor insurance, premiums could be discounted on the basis of persisting evidence of virtuous self management, such as persisting lower cholesterol levels or reduced BMI's, smoking cessation all of which can reduce the incidence of diabetes, strokes, respiratory conditions which have consequential longer term care and support needs. Conversely such discounts could be withdrawn if there is a reverse in such behaviour.

3.18 Where people are enabled to remain supported within their own home, they remain in a position to meet their own accommodation and hotel costs (one of the reasons why we assert that a preference for this outcome should be incentivised in the system). However, in the Commission's proposition, accommodation and hotel costs are excluded from a range of exemplifications and yet these can be as much 40% of the costs of residential and nursing care home costs and therefore, a substantial draw on resources public or personal. It is acknowledged that if these are included in any insurance provisions, this will substantially increase the costs to either the public purse (as at present) or to personal finances.

3.19 There is no satisfactory reason why on entering care homes, people lose access to state pensions and other benefits and are left with a very limited personal allowance for incidentals such as personal toiletries. This leaves people without the means to pay for costs related to food, utilities and rent, which at home they meet. If this accommodation was treated as an extended form of supported accommodation and the citizen is left with the means from pensions, housing benefit and income support to meet these costs (within a framework of regionally set caps, as applies currently to those using housing benefit to access privately rented accommodation), it would enable a clearer identification of the care costs and the resource levels required to support these (see appendix 2- Response from ADASS Continuing Care Reference Group). Self funders not exclusively reliant on state pension do put their income towards such costs, and it would make for more transparent choices if such costs were shown separate from the actual costs of care.

3.20 The system would be less confusing if there was a single continuum of supported accommodation through sheltered accommodation, specialist supported housing, extra care sheltered accommodation, residential care homes (N.B. in some Local Authorities, extra care sheltered accommodation has been commissioned as a viable alternative to residential care) and nursing care homes. The same principle would apply to meeting the hotel costs where nursing home care is provided as part of NHS Continuing Healthcare, making only the care element free (see appendix 2- Response from ADASS Continuing Care Reference Group). There are some technical issues about registration, which as with domiciliary care can be applied to the care provision and to the nature of tenure, (which may need to be shorthold assured or licensed, when applied to current residential and nursing care homes to enable people to move on when circumstances change, as is the case in most extra care

sheltered or specialist supported housing schemes). However this would be an enhancement on the current status of residents in care homes, which is that of lodgers. It should be noted that there are existing provisions in the Court of Protection arrangements that mean either family members exercising power of attorney or Local Authorities under deputyship powers, can enter into tenancies for those who lack mental capacity either through learning disability, chronic mental ill health or dementia related conditions, making this a feasible option for these cohorts.

3.22 For self funders who have equity to trade, there is a growing market in retirement accommodation which is only just beginning to offer care and support services as part of the service charges. This is a more developed offer in the United States and elsewhere, and presents the possibility that people can trade down into such facilities, purchasing a range of financing options to fund care. However the growth of such developments is comparatively slow and is not projected to meet demands in the self funder market. Government and Local Authorities could be encouraged to provide tax breaks, surplus public sites and planning priorities to developers willing to undertake these developments, to then accelerate the growth of this market. A number of such developments have converted residential and nursing homes which are no longer fit for purpose. There maybe further opportunity to consider with Local Authorities and Registered Social Landlords, whether there is substandard sheltered accommodation stock which can either be converted or redeveloped to aid the growth in such developments and which, could be funded through creating mixed tenure developments (units for social rent; market rent; shared ownership and wholly owned). This means that these owned units can be sold to benefit the deceased's estates or to meet deferred care payments. This could prove to be a much more attractive form of equity release.

3.23 We must acknowledge that there is a minority position within ADASS that would continue to support an exclusively tax funded proposition. However there is a majority consensus that there is limited room for the tax increases to fund this. There are significant issues of inter-generational fairness where disproportionate burdens would fall on those currently in work, reducing as a proportion of the population, with fewer resources and assets and reduced access to state benefits and payouts than the retired population currently enjoys or have benefited from in the past.

Conclusion

ADASS continues to strongly support a partnership option (between citizens, communities and the state) where state support is provided to those who lack means, with particular attention to the younger adults (who in the main live on lower incomes and do not acquire wealth), with either life long or enduring

conditions (including physical disabilities, learning disabilities and mental health) requiring ongoing care and support. As described previously, we believe that the state must also consider making some resource available to those with means, to assist in meeting these risks and costs. This must be deployed in such a way as to incentivise people to plan and make provision for the care costs they are likely to face.

We support the proposition that a period of free support for everyone at the point of rehabilitation or other predicted risk prevention interventions would be beneficial. It would help people to construct sensible, well-informed and more affordable support plans. However, we accept that this may have to be offset by the re targeting of the current panoply of universal benefits enjoyed by those with means.

We remain very concerned that options supporting only voluntary engagement of self funders in making provision for their care requirements will not deliver a sustained funding settlement, as there is no evidence anywhere else that they do. If a more mandatory route is to be applied then we have outlined a range of choices and incentives which can be adopted to make it more attractive and affordable to everyone to offset the requirement to participate.

In such an environment there will considerable and understandable pressure for the care and support system to be configured to be more efficient, more cost effective and the parameters for variations to be substantially narrowed.

We conclude as we began, by saying that we expect to benefit from the work of the Commission but it must mark the end to deliberative effort. The next vital step is for actions to be adopted with urgency which are both necessary and sufficient to a sustainable funding settlement for adult care and support.

In summary, ADASS would like to emphasize the following five points:

- **Partnership is the most viable option**
- **A time limited period of free care would enable citizens to make informed and affordable support plans**
- **It is vital that the partnership option has maximum coverage across all citizens**
- **Affordability is key, with systems to be configured optimally to maximise resources and capacity**
- **The Government must make the right resource available to support a sustainable funding settlement**

And finally, ADASS would like to clearly restate the commitment to share its' professional knowledge and position to work closely with the Commission to achieve a realistic and deliverable set of proposals that could form the basis of a new funding settlement, for the mutual benefit of all.

James A. Reilly
Director of Community Services, Hammersmith & Fulham Council
Honorary Treasurer, Association of Directors of Adult Social Services
Lead Director on Response to Dilnot Commission

Richard Jones
President Association of Directors of Adult Social Services

28th January 2011