The United Kingdom Parliament Committee on Public Service and Demographic Change

Joint submission – ADASS, LGA, SOLACE

31 August 2012

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1. About us

2. The **Local Government Association** (LGA) is here to support, promote and improve local government. We will fight local government's corner and support councils through challenging times, focusing our efforts where we can have real impact. We will be bold, ambitious, and support councils to make a difference, deliver and be trusted.

3. The LGA is an organisation that is run by its members. We are a political organisation because it is our elected representatives from all different political parties that direct the organisation through our boards and panels. However, we always strive to agree a common cross- party position on issues and to speak with one voice on behalf of local government.

4. We aim to set the political agenda and speak in the national media on the issues that matter to council members.

5. The LGA covers every part of England and Wales and includes county and district councils, metropolitan and unitary councils, London boroughs, Welsh unitary councils, fire, police, national park and passenger transport authorities.

6. We work with the individual political parties through the Political Group Offices.

7. Visit www.local.gov.uk

8. **SOLACE** (the Society of Local Authority Chief Executives and Senior Managers) is the representative body for senior strategic managers working in the public sector in the UK. We are committed to promoting public sector excellence. We provide our members with opportunities for personal and professional development, and seek to influence debate around the future of public services to ensure that policy and legislation are informed by the experience and expertise of our members. Whilst the vast majority of SOLACE members work in local government we also have members in senior positions in health authorities, police and fire authorities and central government.

9. The **Association of Directors of Adult Social Services** (ADASS) represents Directors of Adult Social Services in councils in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of other responsibilities for the commissioning and provision of housing, leisure, library, culture, arts, community services and a significant proportion also hold statutory children's Director role.

10. A note on our submission and key messages

11. We welcome the opportunity provided by the House of Lords Select Committee to raise the profile of the impact of demographic change on public services. This response primarily focuses on the combined challenge that our aging population poses for the future of our health and social care system. We acknowledge, however, that this is only one aspect of the demographic challenge facing councils and those demographic pressures will vary across different localities. For some local authorities, the increasing number of children with learning difficulties and complex needs, for example, is proving equally challenging. Moreover, some areas will feel the impact of an ageing population more acutely than others in the shorter term.

12. Demographic pressures and continued upwards demand will not only impact on health and social care budgets. The funding gap between revenue and spending pressures, estimated to reach £16.5 billion a year by 2019/20, threatens the future viability of a range of council services. The LGA estimates that, taking out funding for social care and waste services, funding for other council spending will drop by 66 per cent in cash terms by the end of the decade[1].

13. Other factors will also exacerbate the effects of the funding shortfall for social care. Welfare reforms, for example, are likely to be most felt by the poorest in our communities and could lead to negative health outcomes, placing additional pressures on acute services.

14. There are, therefore, many interconnecting challenges that arise from, and are associated with, the shortfall in social care funding. The solution must start with a commitment from the Government to a significant real terms increase in funding for health and social care services.

15. As essential as funding is, we recognise that there are other key ingredients that are essential to delivering the full benefits of a sustainable health and social care system. Integration across health and social care is, for example, critical and will be driven by new models of collaborative leadership. Local government and its partners also need to work in new and exciting ways with and alongside communities, empowering citizens to contribute back to society.

16. This shift away from direct provision towards enabling and capacity building forms part of a wider cultural shift whereby vulnerable people, including the elderly, are no longer seen as a burden to society but rather are respected and the contribution they choose to make to family and community life is valued.

[1] Funding outlook for councils from 2010/11 to 2019/20, LGA, 2012

17. Our submission

18. Celebrating later life

19. People in the UK are living longer than ever before, which is a cause for celebration. But in order to add life to years, and not just years to life, we need to develop communities that provide older people with opportunities to age well and which value the contribution older people can make. This contribution is without question: 65% of volunteers are aged 50 or over and 25% of carers are aged 60 and over.

20. Achieving age-friendly communities requires a change to make social care a 'mainstream' issue in the public consciousness. Social care is at times perceived to be a poor relation to the National Health Service, when such vital services should be seen on par with it. There is a common lack of understanding as to what social care is, why it is important, and why – unlike many health services – it is not provided free of charge.

21. Social care services – their reach, cost and quality – affects a much higher proportion of the population than is probably imagined. Taking into account carers and people who use or work in social care services, disability charity Scope estimates that as many as one in six people in England and Wales are connected to social care in one way or other.[2]

22. Communicating the remarkable reach of social care services is crucial if we are to bring about a shift in public attitudes.

23. Pressures on the system

24. It is a cause for celebration that we are living longer; however, our aging population, alongside other demographic shifts and wider factors, such as the impact of welfare reform or the shortage of school placements experienced in some areas, is exerting considerable pressure on both the health and social care system and public services more broadly.

25. In terms of social care services, if these pressures are left unaddressed, increase future demand will not be met effectively – by which we mean clear, understandable, appropriately resourced care and support solutions that are tailored to the individual. This in turn, will place additional pressure on other parts of the system, such as acute care services.

26. It is our view that the care and support system needs to be urgently reformed and more money needs to be made available to meet demand. If this does not happen, the impact will not only be felt by those who rely on care and support services but users of other council services, as social care budgets eat into remaining council resources.

27. The impact of our aging population on social care services

28. The main focus of this submission is the impact of our aging population on social care services. The statistics are well known and do not need outlining in much detail here. In short the system is facing (and is projected to face) significant increased demand as our population ages.

[2] This proportion is calculated using the latest available statistics on carers, social care users and social care workers in England and Wales.

29. By 2060, 40 per cent of the population will be over 50. By 2030, there is predicted to be a 64% increase in people aged 75 and over, compared to a 16% increase for all ages. The number of people with dementia is predicted to double over the next 30 years. As the older population grows, conversely the number of people working to support those in later life will shrink. As life expectancy increases, so do the pressures on local government.

Ages	**2010 (number of people in thousands)**	**2015**	**2020**	**2025**	**2030**	**% increase 2010 - 2030**
0-14	9,151	9,739	10,395	10,610	10,466	14.37
15-29	10,462	10,611	10,270	10,328	10,907	4.26
30-44	10,775	10,634	11,181	11,920	12,010	11.46
45-59	10,099	10,886	11,063	10,559	10,421	3.19
60-74	7,627	8,075	8,585	9,074	9,848	29.12
75+	4,119	4,523	5,112	6,116	6,756	64.02
All ages	52,233	54,468	56,606	58,607	60,408	15.65

30. Demographic pressures are increasing at a time when resources are shrinking. We need to look at the totality of services for older people and ensure that there are efficient and effective funding arrangements in place which will be fit for purpose in an ageing society.

31. LGA modelling of revenue and service demand shows that a likely funding gap of £16.5 billion a year will emerge by 2019/20, or a 29% shortfall between revenue and spending pressures. This gap reflects the difference between what local authorities across England would need to spend to maintain frontline services in their current form, and the income they will be able to raise from grants, fees and charges, business rates and council tax.

32. Spending on older people already makes up nearly half of social care spending, and as the number of over 85s increases sharply, it is set to rise. We estimate that demographic pressures for this service will cost local authorities in the region of 4% per annum.

33. We estimate that councils finance, on average, about 48% of total expenditure on social care and support through Council Tax, although some councils fund as much as 70%. It is clear that securing the future sustainability of local government must start with securing the future sustainability of adult social care.

34. Given the expected rise in the annual cost of adult social care, we therefore anticipate a funding shortfall by 2014-15. Without significant real terms increases in funding it is likely that there will be considerable pressure on councils' ability to maintain care services on current eligibility criteria in the coming years. The Spending and Saving Survey 2011 showed that more than half of councils were seeking to protect adult

social care (57%). However, Councils will have to make very difficult decisions in order to address increasing demand at a time of reducing resources.

35. The main resource councils use to fund adult social care locally is Council Tax, although as different areas of the country have populations with different levels of resource the amount that can be raised locally varies considerably. Given this has been capped, councils have to use the limited levers available to them to manage demand, principally tightening eligibility thresholds and raising income via increasing fees and charges. The net result of this underfunding has been a growing level of unmet need and then a consequent increase in the number of individuals that ultimately do qualify for council-funded support by virtue of having 'critical' needs.

36. These, of course, are often the most costly. An ADASS budget survey reveals that 85% of councils are now operating at 'substantial' or 'critical' only which illustrates the extent to which some councils are having to ration their adult social care services to keep pace with demand.

37. This survey also reveals that £1.89 billion has already been taken out of adult social care budgets over the last 2 years, despite demographic pressures growing at 3% per year. The survey indicates demographic cost pressures across all groups totalling £425m. 17% of councils are not funding these pressures, 42% of councils are partially funding them, and 41% of councils are funding them in full.

38. The government did respond positively to some of the central arguments made by local government in the run up to the Spending Review. There is new adult social care funding of £530m in 2011-12, rising to £1bn in 2013-14, and a further £1bn funding for joint working with the NHS. These monies constitute the "extra £2bn" that government argues social care has received.

39. There has been £622m worth of NHS investment into social care in 2012-13 and councils have worked closely with NHS colleagues to maximise the use of this additional resource. £284m has been applied to offset pressures and cuts to services, £148m has been invested in new social care services, and £149m has been allocated to working budgets. However, whilst this money is certainly welcome, its impact would only be truly felt if we were in a settled state - the picture presented above with regards to general funding pressures makes clear that we are not.

40. Set against the backdrop of budget constraints on public services and the challenging and uncertain economic climate we are in, we are keenly aware that it would be rash to say that any service area should be exempt or excluded from the potential benefits of constructive re-shaping and re-provisioning. The LGA's new adult social care efficiency programme, part of our productivity programme is explicitly about refining and developing effective approaches to efficiency to deliver the savings councils need to make to meet the challenges of reduced funding and demographic pressures.

41. <u>Specific pressures: special education needs and education</u>

42. An important wider implication of the pressure on adult social care budgets is the impact on other service budgets – an impact that will only increase and, ultimately, become acute for all other aspects of council services.

43. The most obvious area to highlight is children's services and, specifically, children's social care and school place planning, where there is evidence that demand and demographic pressures respectively are making it increasingly challenging to reduce costs (even though productivity is increasing). For example, there remains a legacy impact from the Baby Peter case, illustrated by apparently permanently raised levels of referrals to social care, increased numbers of children and young people requiring protection plans, and rising numbers entering the care system. Department for Education statistics (to March 2011) show, for example, that referrals to children's social care stood at 615,000 in 2010/11, up from 603,500 in 2009/10, and 547,000 in 2008/09.

44. Similarly, urban population growth, most notably in London (but not confined to the capital), is beginning to impact on the sufficiency of school places (primary initially), requiring councils to secure large scale investment in new school estate. Research carried out by London Councils, for example, shows that London faces a shortfall of 70,000 school places between March 2011 and 2015, with the cost of providing enough school places expected to rise to £1.7 billion by 2015.

45. It should also be noted that the role of the local authority in education generally is changing but, importantly, not diminishing – although significant resources have either been taken back to the centre or removed from the funding system as part of the Government's deficit reduction strategy. Local authorities increasingly have championing and commissioning roles, maintaining a local overview and ultimate responsibility for performance, as well as and securing fairness in admissions, for example. Our estimate is that local government in England will see a decline in its funding for services other than schools and children's services over the next four years. The funding reduction is estimated to be about 16% in real terms.

46. Local authorities also are having to cope with increases in numbers of children with additional (special) educational needs:

2005 -10 Percentage increase of pupils with :	
Behaviour, emotional and social difficulties	23% (158,000)
Speech Language & Communication:	58% (113,000)
Autistic Spectrum Disorder:	61% (56,000

47. It is clear, therefore, that attention to tackle the potential funding crisis for adult social care must not take attention away from other, possibly lesser but still significant demand and demographic pressures.

48. School place planning remains part of their core statutory duties. This is not a function that relates only to education and children's services – the whole of the local authority, and public services in the area more generally, are affected by the effectiveness of school place planning.

49. Consequently, whilst meeting the needs of an ageing population is seen overall as the most significant pressure on local government resources now, and over the next 20 years, it must not be forgotten that other critical service areas are not without their own challenges. And it can be expected that these pressures will only grow as councils are charged with not just meeting the needs of vulnerable children, young people and

adults, but also by delivering innovation and quality in other critical service areas such as waste collection and disposal, highways maintenance and economic development regeneration and housing.

50. Specific pressures: younger disabled adults

51. The incidence of disability is rising, and with it the demand for social care. At 11.5 million, disabled people represent a significant slice of the UK population.[3] Broken down further, in 2010-11, some 6% of children (0.8 million) were disabled.[4] Among adults of working age, the prevalence of disability is even higher – at 15% (5.4 million).[5] Higher still is the proportion of adults over State Pension age who are disabled – 45% (5.3 million).[6]

52. The number of disabled people in the UK is increasing – from 10.7 million in 2002-03, to 11.5 million in 2010-11), a consequence of an increasing population overall. As our population ages, so the number of disabled people is likely to rise.[7] Incidence of disability increases with age: proportions range from 13 % of 16-24 year-olds to 70% of over-85s.[8]

53. In fact, among adults aged 75 to 79 and over, adults with impairment form the majority (51%).[9] So too are there decreasing levels of mortality among adults (18-64) with learning disabilities (critical or substantial care needs, only). This is expected to boost this particular population from 220,000 in 2010 to 290,000 in 2030 – a dramatic increase of 32.2% (to put this in perspective, the general 18-64 population is expected to grow by only 6.1% in the same timeframe).[10]

	2010 (number of people in thousands)	**2015**	**2020**	**2025**	**2030**	**% increase 2010 - 2030**
Projected number of younger adults with disabilities						
Adults with a severe learning disability	220	240	260	280	290	32.20
Adults with a sensory or physical impairment	2,890	2,930	3,030	3,110	3,110	7.50
Adults with mental health needs / other	210	210	220	220	220	7.3

Source: Projections of Demand for Social Care and Disability Benefits for Younger Adults in England – the Economics of Social and Health Care Research Unit (2011)

54. In some areas, the pressure resulting from an increase in the number of people with learning disabilities is more of a pressure that that posed by increasing numbers of older people. These trends are also fueling the rising demand for social care services.

[3] DWP *Family Resources Survey - United Kingdom - 2010/11* (DWP: London, June 2012)
[4] DWP *Family Resources Survey - United Kingdom - 2010/11* (DWP: London, June 2012)
[5] DWP *Family Resources Survey - United Kingdom - 2010/11* (DWP: London, June 2012)
[6] DWP *Family Resources Survey - United Kingdom - 2010/11* (DWP: London, June 2012)
[7] DWP *Family Resources Survey - United Kingdom - 2010/11* (DWP: London, June 2012)
[8] ODI *Life Opportunities Survey - Wave one results, 2009/11* (DWP: London, 2011)
[9] ODI *Life Opportunities Survey - Wave one results, 2009/11* (DWP: London, 2011)
[10] Economics of Social Health Research Unit (2011) *Projections of Demand for Social Care and Disability Benefits for Younger Adults in England*

55. The transfer of learning disability funding from health to social care is being achieved through the introduction of a specific grant called the Learning Disability and Health Reform Grant. It amounts to £1.325bn in 2011-12, rising to £1.357 in 2012-13. This funding covers the transfer of costs but not the rising demand and growth which is significant

56. Local government's contribution and the need for a funding commitment

57. Councils have had to face extremely tough choices about which services they can keep on running. Councils continue to show that they are doing everything they can to minimise the effect of these cuts, and building on their record of delivering new and better ways of doing things differently in order to keep public services running. The Local Government Association's Spending and Saving Survey 2011 revealed that councils have cut senior management costs while trying to protect the services that the most vulnerable rely on.

58. The Prime Minister has acknowledged that "local government is officially the most efficient part of the public sector" and that "councils achieve well in excess of the sector's spending review targets, beating central government savings by a country mile" (Rt Hon David Cameron MP, Cutting the Cost of Politics, speech, 2009). Councils made savings of more than £3bn between 2005 and 2008 and a further £1.7bn in 2008-09.

59. Councils know that it is likely that more efficiency savings can and will have to be made, and the LGA is investing heavily in a national productivity programme to assist with this. However, what has to be saved over the next few years goes far beyond what can be achieved by conventional efficiency savings and, moreover, the level of savings achieved to date cannot be sustained.

60. As we have long argued, these difficult decisions are best made at the local level. Councils – working with their local partners – have a thorough and expert knowledge of their communities' needs and continue to strive to ensure that scarce resources are targeted where they are needed most.

61. Despite this success at local level, the government cannot expect Councils to continue to fill the funding gap through efficiencies – this is simply unsustainable, the shortfall is too great. The government must commit to significant real terms increase in funding for social care; reform and funding for the health and social care system must go hand in hand if we are to build a sustainable system for the future. This point has not been recognised by the Government, which has failed to address the issue of funding alongside its plans for reform.

62. For this reason, the government's progress report on funding takes us no further forward on how a modern, stable and predictable social care system can be properly resourced. We have a real sense from the sector that we are in 'last chance saloon' on this issue and that failure to reform now will only lead to more major failure just a short way down the line in terms of the system collapsing.

63. Addressing the future funding question encompasses a number of different issues that need to be resolved:

- Funding the interim period before any reforms are actually implemented to ensure interim increased demand can be met.
- Funding the set up and running costs of a reformed system.
- Funding any shortfall between what a reformed system covers and what costs may still remain.

64. We will shortly be conducting our own analysis of the amount needed between now and the likely implementation of any funding reform post-Dilnot to cope with demand and changing levels of service. This will be done alongside an analysis of the proposed costs of Dilnot's model.

65. <u>Developing an integrated system</u>

66. Increased funding is critical to securing a sustainable health and social care system for the future but if we are to realise the full benefits of reform, we also need to secure an integrated system.

67. The relationship between health and social care is exceptionally significant – particularly given the fact that £1 spent on care services that provide help at home yields bigger savings for the NHS. There are only two options that will address the combined funding pressures on the health and care system: to increase the financial resource available for adult social care; and/or to deliver a substantial shift in resources from the acute sector to preventative work and the community service sector. Achieving the latter will require strong political leadership and new ways of working at different levels within the system.

68. At a national level, the NHS Commissioning Board, the Department of Health and Public Health England (all of whom will have substantial commissioning responsibilities), will need to ensure that their national commissioning decisions support and align with local commissioning plans. The NHS Commissioning Board, will also have an important role to play in ensuring CCGs are working effectively with local authorities through the Health and Wellbeing Board to join up the health and care system locally.

69. It is important that the integration agenda is owned by those jointly responsible for delivery, and that there is a real opportunity for local commissioners to influence a shift towards a total approach to the use of resources, and aligning budgets with strategic planning by CCGs and local government through Health and Wellbeing Boards. This requires a focus on delivering integrated health and care for individuals, underpinned by a clear understanding of the needs of patients and communities, articulated through the individual patient voice and Healthwatch.

70. Integration must not be seen as an end in itself and should instead be seen as part of the bigger goal of reform across councils and the wider health and wellbeing system and focus upon improved outcomes and efficient use of resources. It is also important to recognise that integration may be best achieved at different levels. On one level there is some work to be done on the structures and architecture within partnerships. But more important than the mechanics is the need to foster shared cultures that see everyone involved pulling together in the same direction towards a common outcome, in a system in which differences have been continually reinforced. Local partners have to resolve at the strategic level, the tension between, on the one hand the JSNA which

fosters needs-driven commissioning strategies and, on the other, the more local, asset or place based approaches to finding solutions.

71. Most councils have taken the opportunity to press on with establishing new Health and Wellbeing Boards. They see it as an opportunity to accelerate the horizontal integration of commissioning plans across local public services and to achieve better outcomes for local people. However, the reforms taking place within the health system present additional risks and opportunities for local government. On the one hand, the transfer of public health to local government, combined with a renewed focus on joint leadership through Health and Wellbeing Boards, has the potential to deliver a more joined-up and integrated health and care system that could improve outcomes and deliver increased efficiencies.

72. On the other hand, questions around the affordability of the new role for public health combined with the enormous funding pressures on adult social care, presents a huge challenge for local government and its partners in planning and delivering meaningful integrated health and care services. However, if the right links between social care, health, and public health are made, we can improve services for the people using the system and create savings for the taxpayer.

73. Finally, we must be clear that 'integration' and 'interdependence' are terms that do not just apply solely to the relationship between care and health. A true 'wellbeing' service must include the various interactions between care and housing, transport, leisure and skills to name a few. This is about seeing the totality of a local area's service offer and thinking how it can join up around the individual.

74. If we are to develop more connected communities local government and its partners need to work seamlessly together, at strategic, service management and operational levels, overriding traditional boundaries and driven by new models of collaborative leadership. New systems will require leaders to work together to both improve the health and wellbeing of communities and to ensure that public resources are used in a way which avoids duplications and delivers efficiency whilst retaining an emphasis on quality.

75. Looking to the future

76. <u>The developing context in local government</u>

77. Particularly over the last ten years, initiatives such as Local Strategic Partnerships and Local Area Agreements have opened up local public services and encouraged much closer inter- and intra-organisational working.

78. We have also seen a concurrent shift in how we view the individual receiving services. Whereas we previously may have described things being 'done to' a person, we now see the individual very much as a consumer with increased expectations about the services that should be on offer and the quality of those that are. Informal carers, with their own wellbeing closely linked to the quality of life of the person they are caring for, must also be seen as consumers, experiencing and supporting access to a range of services on offer.

79. The goal is now to join up the different organisations and individuals within a community that each play a part in either providing services or contributing to an

individual's wellbeing. This has further cemented the idea that achieving wellbeing is about making use of the whole range of local services, such as transport, housing (which in particular is rightly assuming greater profile in current debates about the future of care), health, leisure and training and education to name a few. A wide range of local authority functions are therefore fundamental to promoting the health and wellbeing of older people.

80. Furthermore, councils are actively extending individual choice and control through the application of personal budgets (councils are working towards all eligible adults in receipt of personal budgets by April 2013), and working with individuals in seeking improved personal health and wellbeing outcomes.

81. Developing adult social care in the future

82. These dual developments towards personalisation and joined-up services render traditional perceptions of 'social care' obsolete. The service should not exist solely as a 'welfare net' for those with the severest need or most limited means. Rather, it should be about helping people live their lives as they themselves aspire to.

83. We believe such a system should balance both national and local inputs. We summarise these broadly as follows:

- National: a portable assessment of need that is acknowledged anywhere in England, along with a portable assessment of an individual's means.
- Local: decisions about the services to meet need, and the amount to pay for them.

84. People want choice and control over the services they receive. Taking need first, this will inevitably vary from place to place. And as patterns of need vary, it follows that the response must vary too. This will be shaped by other local factors such as the level of council and partner resources, the infrastructure that supports service delivery, the state of the local care market and local costs. This is local knowledge held, gathered or coordinated by local government. These features can only be achieved locally because they depend on a local response to local patterns of need.

85. The practical argument against a fully national system relates to the specifics of how adult social care is funded, and indeed, the way local government as a whole is funded. Despite many people thinking otherwise, funding for social care does not come solely from national taxation. Rather, as the local government finance system is based, in part, on the relative resources a council can draw on, services such as adult social care and support are funded through a combination of central and local funding.

86. Personalising services

87. That local response must look both ways; it should draw down from universal services and include, where appropriate, more specific care and support interventions. We view the universal offer comprising services that support a focus on early intervention, prevention and wellbeing that prevents people needing interventions at a crisis points and effectively keeps people out of the system.

88. The idea of improving the individual's experience of care and support must remain at the heart of any future system. This move to personalisation must not just associated with cash transactions, as this ignores the group of users who are perhaps the greatest

cause for concern: those who seek state-funded services, are ineligible for public funding, yet have very limited means to pay for the care and support they require themselves. For this group, receiving timely and accurate information and advice can be the difference between making poor, costly decisions that ultimately bring them into the state-funded system once their needs have escalated, and good decisions, which maximise their limited resources and maintain their independence.

89. With a range of assessments, means and needs tests, charges, eligibility and interactions with other systems (such as health and benefits) the adult social care system is incredibly confusing for the individual. In many cases getting this aspect of care and support right means preventing admissions to residential care, which we know can be a significant cost pressure for the system as a whole. This would involve a shared territory for local statutory and voluntary sector services, founded on quality information and advice.

90. Developing a national guarantee that is expressed locally, such as we have set out above, means we cannot predict how services will adapt and grow under a truly personalised system.

91. Providers and commissioners alike must broaden their perception of what a person may need – not just for everyday living but also for an independent, fulfilling life. We anticipate services may be smaller, more organic, and cross-cutting between, say, health, housing and care. Regulating a market that seeks to respond to the delicate balance of people's own resources, community support, carers and statutory services may well require a different (or additional) set of standards to those we have traditionally applied.

92. Rethinking design and delivery

93. Conventional approaches begin by measuring what people need, based on problems of ill-health, disability and disadvantage, and then attempt to deploy public-sector resources to meet those needs through a process of setting priorities.

94. Councils and other public sector organisations are exploring the implications of a move away from direct provision, intervention and doing to communities, towards enabling, capacity building and doing with and for communities. This aims to discover and acknowledge the assets that individuals and communities have already.

95. There are many roles that the statutory sector can play in this. Housing with extra care options, good transport and easily accessible information about what's available for older people are just a few examples of things which are key to helping older people live happy, healthy lives. Councils can balance meeting the most pressing needs, like expensive social, residential and nursing care, while maintaining spending on preventive activity is cut back.

96. But this place based approach to ageing starts by looking at the resources available - not simply from the public sector but also from the private sector, the community and individuals. By fully using the wealth of resources on offer, local partners can not only make their areas better places for people to grow old, but can save money too by reducing older people's reliance on social services, the NHS and care support.

97. Meaningful engagement with older people has been a thread running through this approach. This has involved supporting older people to take the lead in finding solutions, rather being seen as part of the problem, with professionals acting as enablers.

98. It also emphasises the importance of the community and its role in ensuring a sense of universality across both services and consumers who are neither advantaged nor disadvantaged by whether they are publicly of self-funded. It requires fostering a sense of collective responsibility for the society-wide benefits of living healthily and planning for the future.

99. Concluding thoughts

100. The Coalition Agreement stated that the government understood “the urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face”.

101. We are under no illusions that addressing some of the issues outlined above, and securing lasting reform is a major task. Several past attempts have all failed, exposing the reality that in a debate about state funding, individual contributions and collective responsibility. We recognise that we cannot simply expect the Government to adopt Dilnot at a time when public finances are so tight. That's why we will work on an offer to central government to show how local authorities can help get us to that fairer, more transparent system.

102. The Government cannot, however, expect local government to bear the load alone. Whilst the sector has excelled in delivering efficiencies, this cannot be sustained over the long term. The Government must enter into an honest debate with the public about what kind of society they want to live in, what kind of social care system they want and how they want to fund it and find a means to deliver a significant real terms increase in funding for health and social care.

103. The Coalition acknowledges that the need for reform is now urgent and we cannot afford any further delays. We need to invest urgently for the short-term, collaborate productively for the long-term, and proceed with all-party consensus. Only this way can deliver for the here and now and for the decades ahead.