FABIAN POLICY REPORT

TAKE GOOD CARE

Improving support and wellbeing in later life

With contributions from Lord Filkin, Barbara Keeley MP, Jim McMahon MP, Heather Wakefield and more

Age UK is a national charity that works with a network of partners, including Age Scotland, Age Cymru, Age NI and local Age UKs across England, to help everyone make the most of later life, whatever their circumstances.

In the UK, the charity helps more than seven million older people each year by providing advice and support. It also researches and campaigns on the issues that matter most to older people. Its work focuses on ensuring that older people have enough money; enjoy life and feel well; receive high quality health and care; are comfortable, safe and secure at home; and feel valued and able to participate.

Hanover is one of the leading national providers of supported housing for older people, managing some 19,500 homes in approximately 600 locations across England and Wales. This includes some 13,600 rented homes and nearly 2,500 extra care housing properties where residents can access 24-hour care on site. They also develop 'downsizer homes' in London and southern England.

Offering a range of attractive and affordable homes and related services designed exclusively for older people, Hanover helps to meet individual needs and local demands. Operating for over 50 years, Hanover's expertise and track record in innovation make it a trusted provider for those wishing to live independent, active and fulfilling lives. It is a not-for-profit organisation – any surplus it makes is reinvested into maintaining its properties, improving services and building more homes for older people.

TAKE GOOD CARE

Improving support and wellbeing in later life

This report explores what the left's agenda should be for older people's care, support, independence and wellbeing. We asked our contributors to consider the offer politicians should make on the services and entitlements older people need to live well; the priorities they should adopt with respect to the development, reform and integration of different forms of support; and the potential funding solutions to pay for comprehensive, high-quality support in the context of rising demand.

The report also presents new Fabian Society research findings on the true costs of funding support and care in England both now and in the future. The current crisis in the provision of adult social care, as well as the government's revised proposals for reforming the funding of supported housing, form part of the backdrop for the project. However this report looks beyond the short-term to seek the positive, future-focused offer that the left should make next.

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Editorial director Kate Murray
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Like all publications of the Fabian Society, this report represents not the collective views of the society, but only the views of the individual writers. The responsibility of the society is limited to approving its publications as worthy of consideration within the labour movement.

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Building a National Care Service

Our social care system needs radical reform. *Barbara Keeley* sets out Labour's bold vision for change

Barbara Keeley is Labour MP for Worsley and Eccles South and shadow minister for mental health and social care

It is now more than eight years since the publication of Building a National Care Service, the last Labour government's white paper on the long-term reform of social care. Billed as the most ambitious change to the welfare state since the creation of the National Health Service, it represented the most comprehensive set of proposals for reform since the 1999 Royal Commission. However, Labour's general election defeat in 2010 meant the white paper was not implemented.

Since then, the coalition and the current Conservative government have tried and failed to deliver personalised care and to settle the inequity of catastrophic costs for care through the Care Act. The provisions of the Act have been crushed under the weight of cuts to social care budgets.

The 2010 white paper included many important features which will inform Labour's new plans for a National Care Service. It constructed six pillars upon which the new system would be built, setting out what people could expect to receive on their journey through social care. It also laid out detailed plans to embed quality in the system. Personalised care, joined-up assessment, nationally consistent eligibility criteria and fair funding were all key elements. Crucially, it also placed principles of prevention, wellbeing and independence at the heart of its vision.

These principles remain part of Labour's vision today, recognising that people want care that focuses on them as individuals, that meets their practical, social and emotional needs, and that treats them with dignity and respect.

Labour's white paper also recognised that the care and support system could not continue to work in a silo. Housing choices, including the role of innovative adaptations and the interaction between social care and the benefits system would also help deliver its vision. These will also inform Labour's future plans.

However, much has changed since 2010. The care sector faces a different scale of challenges. Older people and working-age people with care needs alike are, happily, living longer, but their care needs are increasing. The bill for funding the care and support of older people alone will reach much higher levels in years to come.

But these growing demands for care have been met by austerity and cuts. Over the last eight years, cuts of 40 per cent or more to the budgets of councils responsible for delivering care have led to our care system being hollowed out. The immediate priority of the next Labour government must be to ease the pressure on people in need of care and their families.

The social care provider market, now almost wholly private, is faltering as a result of the diminishing fees that councils which commission care can offer. Quality is worsening as financial pressures mean that it is mainly underpaid and overworked care staff who struggle to meet growing demand.

Levels of unmet need have risen with 1.2 million older people with care needs managing with no help and there are 400,000 fewer people now receiving publicly funded care compared to 2010. The unpaid back pay bill for overnight shifts worked by staff caring for people with learning disabilities could see many care providers having to reduce their services or close down altogether.

Labour's approach

So, we must take a staged approach to reforming the system.

First, to improve quality, we pledged in our 2017 manifesto to invest £8bn across this parliament, with £1bn upfront in the first year of a Labour government. That commitment remains and would enable funding the real living wage for care staff, as well as improving other working conditions. Both would bring some stability to care provision.

The second phase would be to put in place the building blocks of a new system, placing a maximum lifetime cap on costs. We can no longer ignore the manifest unfairness of the current system, which sees

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people with cancer receive free care on the NHS, while those with dementia and their families incur hundreds of thousands of pounds in social care costs.

That is why we have committed to a lower care cost cap than the £72,000 which was proposed, but then abandoned, by the Conservative government. There would also be a higher asset threshold than that currently set at £14,250.

Our third step would be to introduce a fully-fledged National Care Service, which would enshrine in law clear national eligibility criteria to make care assessments consistent and portable across the country, ending the postcode lottery in social care.

In achieving our vision, it has to be acknowledged that the cost of an entirely state-funded system of provision, which would be reliant on buying up large swathes of residential care homes and reversing decades of privatisation, would be prohibitively costly in the short term.

But we know that the fragmentation in the current care system has often led to worse quality care and we need to take steps to improve that. It will be vital to command public confidence in the new system, so that those paying in can be sure that they will be getting good quality for their contribution.

One step to bring improvement is to require councils to commission care ethically. Commissioners can play a crucial role in driving quality but their capacity to commission and monitor services has been drastically reduced by years of budget cuts, undermining their ability to shape local care markets.

In the current care landscape, commissioning often cannot achieve a wider purpose beyond finding whatever care is available, even if it is of poor quality. So our reforms will seek to spur greater innovation, as well as increasing the quality and sufficiency of care.

Good quality care rests on care staff who are properly paid, with the right values and with opportunities for training and development. So we will explore ways to ensure that commissioners purchase care from providers with certain workforce terms and conditions as a minimum requirement

Providers would also be encouraged to have effective training, development and supervision for staff and sign up to ethical care agreements. We could also prioritise commissioning from organisations with a social purpose, from within the voluntary sector and from social enterprises and mutuals.

Good quality rests on long-term relationships. For all people with care needs, older and younger, the evidence suggests that newer, innovative models of care which harness these long-term relationships, like the Shared Lives and Home Share schemes, provide outstanding care. We need to explore how the National Care Service can put these relationships at the centre of provision.

Evidence also suggests that smaller locations, where relationships can be more personal, deliver the best care. So we are keen to explore what role these models of care, and the settings that support them, can play in our National Care Service, by assessing their scalability.

We know that reforming our care and support system has already proved to be one of the greatest political challenges of the last 20 years.

But we must grasp the opportunity to bring lasting, positive change to the way people receive care, to enable people of all ages with care needs to live independent lives.

The next Labour government will take the historic, bold and far-reaching steps needed to bring social care back from the brink and establish a lasting settlement for the benefit of everyone in need of good quality care. F

The numbers game

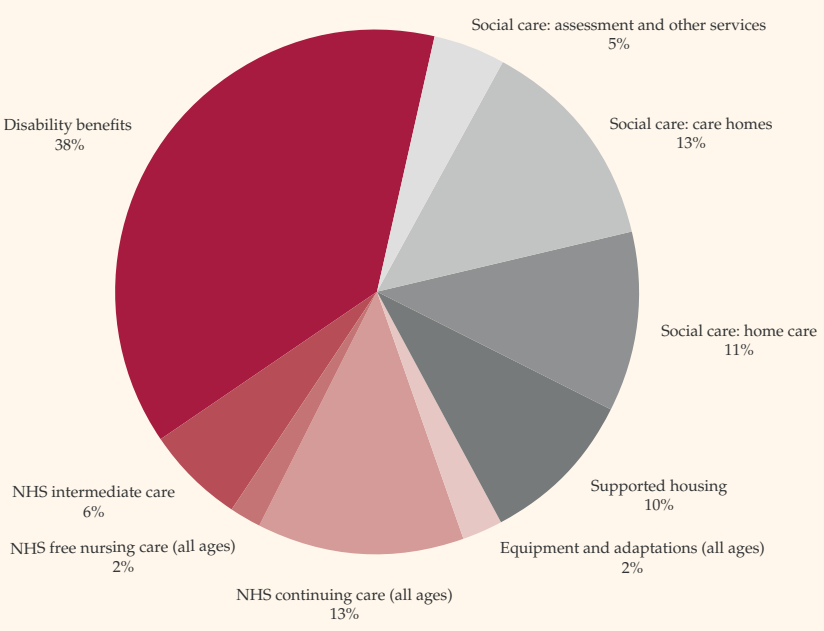
The spending pressures facing older people's support and care are immense – and set to increase. If we are to tackle the crisis, we need to go beyond today's debate and fundamentally reform the way we pay for all the programmes that assist older people to live well, argues *Andrew Harrop*

Andrew Harrop is general secretary of the Fabian Society

We need to change the way we plan and pay for support and care in later life. When policy-makers and politicians talk about support for older people to remain independent they usually mean adult social care. But a new Fabian Society research paper published alongside this report shows that social care comprises only 30 per cent of the spending dedicated to helping older people in England with support and care needs. It is just one part of a package that also includes disability benefits, supported housing, equipment and adaptations – as well as NHS services such as rehabilitation, free nursing care and continuing healthcare (figure 1). Our policy debate is therefore too narrow and fragmented. We need to look at £25bn of public spending in the round – not just the £7bn spent on social care.

When you look across all these programmes, it is striking how expenditure is so polarised between high-volume/low-level needs and low-volume/high-level needs. The former mainly comes through social security – ie disability benefits and housing benefit paying for supported housing. As this is demand-led, it has been resilient to cuts and increasingly provides

Figure 1: Social care comprises less than 30 per cent of the £25bn of annual public spending on older people with support needs in England



the only help many older people receive. The latter high-intensity support is delivered through social care, NHS nursing care and NHS continuing care. But in between, very little is spent on intermediate support for people who need help to live independently but are not in acute danger without care. Time-limited NHS rehabilitation services are the only exception.

What's more, cuts in recent years have particularly focused on medium needs. Far fewer people are judged eligible for social care than before 2010 and traditional supported housing schemes are offering less intensive support than in the 1990s. Without any explicit debate or decision, the state has withdrawn from supporting intermediate needs. But barely any of the present policy debate is focused on reversing this trend.

The case for spending more

The truth is that a lot more money needs to be spent on meeting older people's low-level, intermediate and high-level needs. The Fabian Society has reviewed existing projections and found that just to maintain current levels of provision across the programmes listed in figure 1 public spending in England will need to rise from £25bn now to £40bn in 2030 – or from 1.2 per cent of GDP to 1.8 per cent. This is equivalent to an increase in real spending of 3.8 per cent every year.

This is not a worst-case scenario: the future spending pressures could be even greater. Most of the projections we reviewed are based on quite optimistic assumptions about older people's future health (with the DWP's projections for future social security spending particularly open to challenge). The figures also assume that carers continue to provide the same proportion of care and support as they do today – which requires a very large increase in the amount of care provided by older people's partners, adult children and other relatives and friends. This might prove impossible for family and friends to supply, unless the state provides them more support too.

These estimates are based only on health and demographic projections so they assume current patterns of provision continue even though they are totally inadequate today. In other words, the figures roll forward the huge recent cuts in the numbers receiving home care, the inadequate size of many care packages, the underfunding of care homes and the undersupply of supported housing.

So how much might it cost to meet fully the needs of older people as they stand today? The Fabian Society's review of the evidence suggests it could take an extra £10bn of funding each year, even under current means-testing rules. The majority of this sum is needed to fill the gap in meeting intermediate needs: £5bn to provide help to 1.2 million low-income older people currently without adequate support for essential daily tasks; and £1.5bn to extend NHS rehabilitation services to all who could benefit.

On top of that £1.3bn is needed to address the existing under resourcing of state-funded care home places and the remainder is needed to increase support for preventative, low-level interventions. A total of £1.3bn could be spent on community services to improve wellbeing and tackle isolation and £900m on funding more people to live in supported housing (the provision of retirement and extra-care housing is very low in England compared to other Anglo-Saxon countries and one industry estimate suggests the market could nearly double in size).

To sum up, in England government is today spending £25bn a year to support older people when £35bn is probably what is needed – and demographic pressures mean spending now has to rise very fast just to maintain existing provision. In an ideal world we should be aiming to address both these challenges together, but combined they command a very hefty price-tag. The Fabian Society estimates that to fully meet all needs by 2030 would require spending to rise from £25bn now to around £60bn in today's prices (ie from 1.2 per cent of GDP to 2.8 per cent). In annual terms this is equivalent to a real rise in spending of 7.5 per cent a year – and that is with a system that still remains in part mean-tested.

Figure 2: Extra spending requirements for each service area by 2030 to respond to rising levels of need

Service	£ billion
NHS continuing care (all ages)	£4.4
Social care: home care	£3.5
Social care: care homes	£2.4
NHS intermediate care	£1.5
Disability benefits	£1.2
Social care: assessment and other services	£1.0
Supported housing	£0.8
NHS free nursing care (all ages)	£0.5
Equipment and adaptations (all ages)	£0.2
Total	**£15.6**

Figure 3: Public spending scenarios for support and care for older people in England (£ billion, 2017/18 prices)

The tough choices ahead

Supporting older people to remain independent is something society should take pride in and expect to spend a lot of money on. But the extent of future need means that even if a lot more public funding becomes available it is highly unlikely that we'll be able to pay for everything we might want to. There will be difficult trade-offs between:

- appropriately funding the support already on offer under current eligibility rules;

- reducing unmet need by expanding the range of support available;
- investing in the most cost-effective support and
- offering fairer funding to affluent older people.

This is the backdrop to the question of means-testing, which always dominates this policy debate. Looking across all the support older people receive, a sizeable proportion is available universally, mainly via social security or NHS services. But adult social care is means-tested and there are good reasons for wanting to extend publicly funded care to richer older people. But given all the other calls on spending, with finite resources, any policy in this territory has significant opportunity costs.

Even when it comes to providing more government support to affluent older people, there are competing priorities. These are evident from the rival conclusions of the three major reviews of care and support conducted over the last 15 years. The priority of the 2006 Wanless Review was to reduce unmet need, which led it to propose public match-funding from intermediate needs onwards to promote the take-up of support. The priority of the 2011 Dilnot Review was 'horizontal' fairness among wealthy older people, which led it to propose a cap on lifetime costs to pool the risks of prolonged needs. And the priority of the 2014 Barker Review was for fairness between people with different health conditions and integration across health and social care, which led it to propose free social care for people once they had very high needs (with the quid pro quo of accommodation charges for care home residents entitled to NHS continuing care).

Perhaps the solution to this dilemma is to forget about the difficult trade-offs and just argue for extra money for everything. But one projection suggests that a reform to older people's social care in England that both relaxed eligibility criteria to meet intermediate level needs and offered free universal care would cost more than £8bn now, rising to over £14bn in 2030. In an ideal world, a government of the left might chose to raise taxes to pay for all of this, but we need to remember there will be other competing priorities for enhancing the welfare state (including spending on pensions and healthcare for older people which each need to increase as a percentage of GDP).

At the outset of this project I was hoping that the evidence would allow me to argue for universal publicly funded social care. But the Fabian Society's review of all the parallel cost pressures has made me doubt whether this is the right priority for now. A limited entitlement, such as a lifetime cap on care costs, is probably preferable to making an under resourced offer of funded care for all, which could result in insufficient resources being available for older people with low incomes. So for now politicians should only make a partial offer to affluent older people – whether that is on the lines proposed by Wanless, Dilnot or Barker. The cheapest option is the cap on lifetime spending legislated for in the Care Act. Politicians should commit to this now, without ruling out other measures to reduce means-testing further in the future. But most of any extra money available should go to meeting the other financial pressures in the care and support system.

Supported housing and care homes

As we have seen, it is not just a question of funding social care. Future decisions on how to spend each marginal extra pound need to be taken across service silos. In particular, supported housing and home adaptations must not be side-lined just because they are funded by other arms of government. Housing spending is often very cost-effective because it sustains independence and prevents the need for more acute and expensive services. Yet today housing-related support only accounts for 12 per cent of the total public spending for older people identified in figure 1. This proportion will decline further in future if the supply of supported housing does not rise and if new spending simply flows to those with the very highest needs. Planned choices are needed to ensure that such preventative interventions are not squeezed out.

In this context careful thought needs to be given to capital investment. Recently the government has chosen to increase capital spending on home adaptations through the disabled facilities grant. But there is no obvious strategy for expanding the stock of care homes, extra care housing and supported housing. Published projections suggest that around 11,000 more care home beds and 9,000 more supported housing units for rent need to be developed each year to keep up with rising levels of need. The mix between the two could be adjusted, if there were more high-support extra care developments. But as things stand there is no coordinated

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planning or funding to manage and finance new developments for either form of accommodation.

The government's de facto strategy is for investment to be self-funded through the future flow of rents and fees. However, in the case of care homes the fees paid to operators are now too low for them to fund capital investment to expand or upgrade – even though rising demand means we will need 50 per cent more beds in 2030 than in 2015. Similarly, social landlords need financial certainty to invest in supported housing including extra care schemes. Their future revenue stream is a little clearer now that the government has confirmed that housing benefit will continue to fund eligible rents and service charges for supported housing. But the financial model for extra care schemes is particularly complex as they depend on funding from housing benefit, home care, local authority grants and user charges.

A new funding system

Whatever the detail of future decisions, politicians will need to make the case for high and sustained spending increases for older people's support. This requires a transparent and coherent strategy which should consist of three components. First, rising receipts from existing taxes can pay for expenditure to rise in line with GDP. For this to happen current austerity policies need to end. Second, broad-based progressive taxes can pay for spending to keep up with much of the rising demand. Historically, we have taken this for granted when it comes to funding the NHS and we should not exclude other forms of support for older people from the same approach.

Third, affluent older people should pay more taxes as part of a 'something for something' deal that improves the support available to them (rather than just expanding what is there now in line with rising numbers). In particular, any new universal entitlements that benefit richer older people should be paid for by this group because their rationale is 'horizontal' distribution within the cohort of the rich/old, towards those unlucky enough to have long-term support needs. The choice about how generous the universal offer should be will therefore come down to how much older people are willing to pay, in the context of a well-managed democratic debate.

Additionally, adult social care should no longer be financed from general local government funds. As things stand, social care is neither a direct responsibility of central government like the NHS; nor is its funding demand-led like disability benefits or housing benefit for supported housing. Instead social care competes for money from cash-strapped local authorities that

> A combined budget for health and social care is probably the best option in most places

are largely funded by council tax and business rate payers, the vast majority of whom do not use care services. In 2015/16 adult social care (for all age groups) accounted for 33 per cent of local government spending in England. By 2030, this figure will rise to 46 per cent if adult social care spending grows to reflect rising needs and council spending increases in line with projected GDP growth. This is totally unsustainable.

Three options should be considered to replace general local government funding – and they could be used side-by-side in different locations:

- a ring-fenced grant to councils for adult social care, like the designated grant for schools;
- an integrated local budget for health and social care;
- a single budget for all local public services in areas with high levels of devolution and robust democratic institutions.

A combined budget for health and social care is probably the best option in most places, in order to drive service integration and preventative investments. But commissioners would then need to avoid creating new boundaries between health/care and other services, especially housing.

There is also a good case for reforming the role social security plays in resourcing care and support. The importance of demand-led benefits has been proven by the austerity decade. Since 2010 disability benefit expenditure for older people has risen in real terms to reflect the ageing population. With social care restricted to fewer and fewer people disability benefits have been the only certain source of support for most older people in need of support. Similarly, demand-led housing benefit provides over £2bn of annual funding for older people's supported housing in England. It provides long-term certainty to social landlords and in principle allows them to plan new developments with confidence.

Demand-led benefits also keep the government honest by transparently exposing rising costs as more people become eligible for help. They should therefore have an expanded role in funding care and support. At present, disability and housing benefits are not available to publicly supported care home residents. This creates an arbitrary financial divide between care homes and extra care housing schemes and is a hidden tax on local authorities of £2bn each year. So in the future publicly funded care home residents should receive housing benefit and disability benefits on the same basis as supported housing tenants.

If this new social security spending was added to the existing resources available for support and care (without a parallel reduction in other revenue streams) it would significantly expand the total money available and would be a big step forward in addressing current underfunding. But even if extra social security spending only replaced social care funding pound-for-pound initially, the policy would still be beneficial. It would provide buoyant, demand-led revenue in the future, creating a more automatic and flexible response to rising need.

Talking about social security as a solution to the social care crisis is proof that it is time to change the terms of this debate. We need to stop thinking about social care in isolation and take a much broader view of all the forms of support older people need. We need to consider the many different ways of raising extra money and how to rewire the machinery by which it reaches older people. We need to get real about the tough choices that will need to be made, because doing everything is unlikely to be affordable. And above all, we need to adjust to the reality that very large annual spending increases are needed if we are to deliver decent support and care in old age.

- *The full Fabian Society findings are available at www.fabians.org.uk*

Getting it right

The social care system is fragmented and underfunded. But David Walker says we should rule out a big bang response

David Walker is contributing editor, Guardian Public and a former director of the Audit Commission

Bedford is carrying out a £3.5m upgrade of its residential homes for older people, improving bathrooms, replacing boilers and pipework where necessary, installing access ramps, remodelling and putting in car parks and paving.

Councillor Anthony Forth, portfolio holder for adult services in Bedford, says: "Care homes came back under local authority management in 2014, which gave all staff the opportunity to be harmonised onto the council's terms and conditions including the national living wage. I am delighted that we have been able to undertake these works and enhance the experience of those who live in these homes."

The vignette is not offered to make a party point. Forth is a Labour councillor but the borough is in no overall control and the executive mayor is Liberal Democrat. Rather, it is meant to show that some councils in England are doing a creditable job; it is not all doom and gloom. The narrative around social care is often coloured by pessimism about policy, public attitudes towards tax and dismay at the public's unwillingness to do even basic due diligence about their own and their family members' likelihood of needing and being able to afford care. Social democrats especially should resist cynicism and fend off the temptation to put issues – 'wicked' as they may be – into the 'too difficult' box.

An optimist might even add that political support for austerity is collapsing. Polls show more positive attitudes towards tax; Conservative councillors and MPs are now prepared to say out loud that things can't go on as they are.

But back to Bedford. Privately owned Kimbolton Lodge charges £800 a week for personal care and over £1000 if nursing is needed. Meanwhile, Highfield Residential Home in Brickhill notes Polish under the heading 'languages spoken by staff other than English'. Brexit is already having bad effects on staffing in a sector that the Commons Public Accounts Committee says is already in a 'precarious state'. As for local liaison between health and social services, commissioners recently insisted on competitive bidding for community health services, resulting in the arrival of an East London trust and the withdrawal of the incumbent Cambridgeshire trust. So much for continuity.

However commendable Bedford Borough's investment, the council is only one supplier in a marketplace where private enterprise can still make money. It is a market (according to the Competition and Markets Authority) bifurcating between a profitable upper end – fuelled by equity withdrawal and the liquidation of vast domestic property holdings and a lower end, where eligibility criteria and public supply become ever tighter. In the middle, where older people are, the strains show.

Describing what's wrong is not hard. We now have a library of excellent descriptive and analytic reports. We know how deep some of the causes of policy failure go. It is the 50th anniversary this year of the publication of the Fulton Report by prime minister Harold Wilson: all too many of its criticisms of capacity and departmentalism – and the unwillingness of the treasury and the Whitehall system to think strategically and forward in time – still apply. These failings have been exacerbated under right-of-centre ministers intent on diminishing collective provision and, in some cases, on undermining public service.

But we should avoid the temptation to respond in kind, with dogmatic left-of-centre statism – however vital government is going to have to be in securing the well-being of an ageing Britain. Andrew Harrop in his chapter for this collection emphasises the segmented, fractured nature of policy response. That does not however imply the creation of a 'department for the ageing', which would become a generational lobbying group and might even increase fragmentation in policy by neglecting tomorrow's older citizens. The latter are today's young people, who may end up in private rented housing in later life and on whose behalf planning policy should, contemporaneously, be insisting on the maximum adaptability of new build and conversions, to create lifetime homes.

True to our name, policy in this arena has to be incremental and Fabian and look for small advances. Political circumstances and public attitudes rule out a 'big bang'

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response. No one-off tax increase; no nationwide offer on social care; no immediate joining up of housing, care, the NHS and social security.

But, joining up can be accomplished step by step and place by place. Harrop proffers three precepts, the first of which is about silo thinking. The best place to mitigate it is place, ie local government. This looks like the most practicable envelope for planning and thinking strategically about our lives in older age, including the flow of benefits and, especially, where we age.

On the plus side, councils are already densely involved, not just with individuals and families through social work, care assessments and so on but are increasingly players in local economies, able to marry planning and housing provision.

On the minus side, council performance is inherently variable and dependent on the happenstance of whom the local party system throws up. Even if – and it's a big if – grants to local government underpinned relative equity of provision, local political and service cultures would deliver non-uniformity, moderated by inspection and inter-council comparison of performance.

Harrop's second precept is more money. Yes, it is evident that spending must rise – the question is how increases in collective consumption and investment (taxation) can be legitimated and organised. The Institute for Fiscal studies says needed resources can only come either from national taxes on income (including national insurance) or sales (VAT). But sparking a national conversation about paying for social care has proved difficult. Maybe that is because it is at the wrong level. Might the social care money conversation best be carried on locally? Councillors, social workers, care organisers and other local staff sift claims and, without acknowledging it, 'do' distributive justice. Might their role be recognised and expanded? Local authorities have the capacity to share learning and disseminate information more effectively than national departments.

Yet councils have been notoriously reluctant to talk money with citizens: resistance to local taxation has a sharp history, in which Margaret Thatcher was a victim of her own foolhardiness. Councils' own tax raising is in dire need of modernisation and expansion.

Families and the individuals within them are hugely variable in their needs and capacities but will remain the basic unit in which people age and become dependent. That social fact, along with affordability, leave us with means testing. This is agony for the left, which as Harrop notes, is perennially pulled in the direction of universalism. But councils already apply tests of income across a wide variety of services, from collection of garden refuse to access to supported housing: the tests if not their outcomes are widely regarded as 'fair'.

Apart from marketising ideology, no significant challenge has been raised to the central, egalitarian model on which the NHS more or less operates. By instinct I am a social policy centralist. But on social care I am a localist. If the financial pressure on councils could be eased, it is local government that can and should plan, organise and – partially – provide for much of wellbeing in older age. **F**

Healthier and happier

Longer lives are an opportunity not just a burden. Politicians need to sign up to a manifesto for ageing better, writes *Geoffrey Filkin*

Lord Filkin is chair of the Centre for Ageing Better. He chaired the House of Lords committee on our ageing society

Our ageing society is both our biggest social change and our greatest achievement. It is made up of two separate trends; first a continuing growth in the number of people who are older in our society, as the baby boom birth cohort enters retirement. The Office for National Statistics projects a 51 per cent increase in people aged 65+ between 2010 and 2030. Second, we are enjoying a remarkable extension of our lives. A person aged 65 is now likely to live 10 years longer than their parents. Fifty per cent of girls born this year will live to 100 or more. This extension of life is a social revolution that already offers many of us more years of wellbeing. Yet public discourse about our ageing has focused on the negative story of the increasing costs of health, care and pensions from a larger older population and largely missed the great opportunities our longer lives offer us. We need politicians and all political parties to recognise these opportunities and commit to making it possible for everyone to benefit from a longer life, not just the privileged.

There will of course be significant increases in demand and cost for health and social care services over the next decade, only partly driven by a larger older population. This has been forecast by many studies including the House of Lords report I chaired.[1] But politicians have been slow to accept this and to recognise it requires much more funding. Politicians have failed to explain to the public that additional funding is necessary, that it can be afforded, albeit with additional taxation, and that it should be paid for fairly across the generations.[2] Above all they have failed to explain that there are great opportunities for individuals and society from longer lives and it is worth planning and paying for them.

But the biggest public policy challenge of our longer lives is not funding the NHS and social care but the shocking social gradient in ageing. Lives that are much longer are already greatly enjoyed by some sections of society – but not by others. Poorer people and poorer communities live shorter lives and become ill or disabled earlier. Poorer people are disproportionately affected by high rates and premature chronic ill health conditions and live less happy later lives. The lives of people in Blackpool are 10 years shorter than those in Kensington; they get ill and disabled earlier, and they fall out of work more often. Addressing the striking inequalities of wellbeing in later life ought to be the focus for all politicians – but it has been surprisingly ignored across the political spectrum and treated as if it was an immutable fact of life. What do we need to do to address this?

The evidence is clear what makes for a good later life. If, as individuals, we sustain good enough health, are not too worried about money, live in a decent home, have good relationships and a sense of purpose, then we are much more likely to have a happier later life.[3] But far too many people miss out on these opportunities. So what changes are needed so that many more will benefit?

Public debate about our ageing society mostly focuses on people when they are already old. But the key point is that it is too late to address a good later life when we are retired; our prospects for enjoying our later lives are greatly affected by what happens before we are old. Four factors negatively affect this:

- Unhealthy lifestyles, smoking, alcohol, inactivity, obesity.
- Early exit from the labour market and low savings.
- Poor homes and environments that do not sustain our independence.
- Lack of friendships and meaning in our lives.

1 *Ready for Ageing?* House of Lords 2013 and The Long-term Sustainability of the NHS and Adult Social Care, House of Lords 2017
2 *A New Generational Contract*. Final Report of the Intergenerational Commission, The Resolution Foundation, 2018
3 Centre for Ageing Better 2014

Consider some of the data that supports this:

- Around a third of people aged 50 and over who stop work before they reach state pension age experience a 50 per cent or more drop in household income.
- A third of 55 to 64 year-old women have no private pension savings.
- More affluent people have fewer depressive symptoms, greater life satisfaction better quality of life and lower levels of loneliness.[4]
- People aged 50 to 64 with two or more limitations in activities of daily living reported very low ratings of life satisfaction and quality of life, high levels of loneliness, and elevated depressive symptoms.
- 40 per cent of the years of healthy life that are lost are preventable through modifying health behaviours (smoking, diet, alcohol, and physical activity), metabolic factors (e.g. high blood pressure) and environment (e.g. pollution).
- Yet 70 per cent of adults do not follow government guidelines on two or more health behaviours.
- 20 per cent of homes occupied by older people fail the Decent Homes Standard.

We need a cross-party political commitment to close these causes of the inequalities in wellbeing, life expectancy and disability free life expectancy so that more people live longer, are financially secure and are in good enough health to enjoy their longer lives.

Because what we do before we are old greatly affects our prospects for a good later life, public policy and individuals need to focus more action on this life stage – roughly people aged between 50 and 70 – and to focus again on those at risk and on the changes that matter most for a better later life.

A manifesto for government and social action to address this should consist of:

- **Many more 50 to 70-year-olds living healthier, active lives** – reducing their risk of poor health and disability and avoiding, delaying the onset or slowing the progression of disease and disability. We need a much stronger political commitment to healthy lifestyles and to develop a powerful and radical National Strategy for Healthy Ageing.
- **Many more 50 to 70-year-olds living in homes ready for their ageing, which are safe, warm, dry, accessible and adaptable** allowing them to remain independent and active for longer. New homes must obviously be age-friendly. Poor owner occupiers in bad homes who lack the resources to modernise their homes need solutions. And the growing number of older private renters must be secure and have decent standards.
- **Many more people able to keep in good quality work for longer**. Keeping in work is critical for many to have adequate income in later life and in good work with fair pay, security and progression. Employers will need to get much better at retaining older workers through support and flexibility – they will need them.
- **Many more people involved in their local communities** – with close relationships and wider networks of support. Frequency of contact with friends and relatives is positively associated with life satisfaction and quality of life.

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There are signs that this agenda for change is being recognised. The government has a Fuller Working Life Strategy, albeit needing more power and cross-government support. And on 21 May the prime minister made a major governmental commitment: "Through our healthy ageing grand challenge, we will ensure that people can enjoy five extra healthy, independent years of life by 2035, whilst narrowing the gap between the experience of the richest and poorest."

These are the key elements for an agenda to reduce the waste of many later lives being lived with poor wellbeing and to close the shocking inequality gaps. The issues will need the persistent support of all parties and all politicians at national and local level. The Centre for Ageing Better is committed to work with others over the next decade to promote the actions needed to bring these about.

It should be unacceptable that in some communities people die 10 or more years earlier and that many people become prematurely ill, old and disabled when others are having the time of their lives at the same age. We know much of what we need to do to change this – now we need the political commitment to do so. The prize will be a happier, healthier society, a more productive economy, more fiscally sustainable public services and significant increases in wellbeing across our society. **F**

4 English Longitudinal Study of Ageing (ELSA) Wave 4

Home sweet home

Good quality housing in later life can promote independence and wellbeing – and save the NHS and care system hundreds of millions of pounds a year. *Clare Tickell* outlines why a national strategy for older people must have housing at its heart

Dame Clare Tickell is chief executive of Hanover

We all know the UK has a rapidly ageing population, but the hard facts are stark. Thanks to improvements in healthcare and lifestyles, around 16 per cent of the population in the UK are now over the age of 65. This older demographic is also our fastest-growing group – the Office of National Statistics estimates that the number of people aged 75 and over will rise by some 89 per cent by 2039.

These seismic demographic shifts have big consequences for policy-makers, particularly around issues relating to health, wellbeing and housing. The needs, and indeed expectations, of older people are becoming more complex, with many older people having multiple long-term health conditions and living in homes which are largely unsuitable, as people become more frail if they are to age in place. With the population of over-75s set to nearly double in the next 20 years, it is essential that government policy aims to have appropriate housing stock to meet demand and reduce the impact on public spending, particularly around social care and the NHS.

The problem

Although around one-third of all households in England are older households, the clear majority of those older people live in mainstream housing that is not designed to meet their changing needs.

The lack of supply to meet the demand for retirement housing has become increasingly apparent. As a guide, in the UK only 725,000 homes across all tenures can be classified as 'retirement housing'. This equates to around 2.6 per cent of all homes across the country.

The older population is as diverse as any other and so it is inappropriate to generalise about housing needs and specify an ideal home. We need different types of housing, with appropriate regional variants, to accommodate the changing needs and aspirations of different types of older people, allowing choice and affordability. How and where older people choose to live will vary depending on a range of factors and potential barriers such as age, health, mobility needs and any care requirements.

> Older people living in retirement communities experience lower levels of loneliness and higher measures of quality of life

In 2017, around 99.5 per cent of homes owned by registered housing associations (including sheltered housing) were at a decent standard. However, according to the Building Research Establishment more than one fifth of all older household groups (21-22 per cent) lived in a home that failed to meet the decent homes standard in 2012, the vast majority of which were privately owned homes. In addition, the suitability of housing is problematic given rising care needs – more than a half of over-50s with some element of physical disability live in homes without any health-related adaptations.

With only a very small amount of specialist housing stock for older people, there is a clear shortfall of housing for this burgeoning segment of the population. The International Longevity Centre has calculated that there would be a sheltered housing gap of 160,000 homes by 2030 if current trends continue. Failure to address this scarcity could lead to older people prematurely going into care homes and put even greater strain on an already overstretched health and social care system. Bold and decisive measures will need to be put in place to avoid this scenario.

The ONS estimates that half of people over the age of 75 live by themselves. In England that equates to around 2 million people, with a large number reporting that they can often have no social interaction with others for weeks. Whilst for some people, living alone is a choice, it is also the case that older people living in retirement communities experience lower levels of loneliness and social isolation, and higher measures of quality of life than groups living elsewhere in the community.

The right housing

To begin, government policy must focus more on supporting the expansion of the provision of housing that caters

for older people. Much of the debate around the housing crisis focuses on first-time buyers. However, this ignores the potential benefits that would come as a result of addressing the scarcity of suitable retirement properties across the country. Of course, a key feature – and added appeal – of social housing for older people is that it is affordable. Residents moving to this type of housing can also benefit from lower utility bills and staff can support residents with income advice. International research shows that sheltered accommodation – compared with independent living in the community – can help bring people together, providing added value in terms of autonomy, sense of security and quality of life.

Various studies have quantified the outcomes of sheltered housing on health and social care expenditure. Research by Demos in 2017 on behalf of Hanover, Anchor and Housing and Care 21, has quantified the social value of sheltered housing at nearly £0.5bn per annum. Available facilities at retirement developments can save health and social care services millions of pounds every year by improving the health and wellbeing of the people living there. Their potential to free up housing for the benefit of younger buyers and growing families should also be acknowledged in the planning system.

Governments must also view good quality, accessible housing for older people as a form of preventative health care, an integral part of an interlocking system that can enable independence, promote good health and ultimately help reduce the cost to the NHS and social care system.

It is obvious that early intervention, prevention and emphasis on wellbeing for older people are vital to prevent unnecessary hospital admissions and enable people to stay in their own homes. But this is not just about savings, it's also about better outcomes. There is certainly growing awareness and appetite between professional partners that joint thinking and planning – and determination of services – must be the way forward.

Housing and health

In Greater Manchester, Mayor Andy Burnham is right to assert that housing is a health issue. Likewise, he is right to say that without faster and more radical solutions around housing, the crisis will not be solved. As a housing sector we have the ability and expertise to help influence what housing is built, and where. To do this effectively would mean ensuring housing features in integrated models of care. It would involve working even closer with local authorities, clinical commissioning groups, NHS trusts and other key stakeholders.

To that end, we know that local planning through sustainability and transformation plans (STPs) is varied. Although there are some good examples, most STPs do not include housing as a core theme. Similarly, housing also doesn't feature a great deal in the NHS care model vanguards.

Ultimately how the needs of an ageing population are addressed is a cross-departmental, cross–sectoral issue. There are excellent examples to draw on across the country involving housing, health and social care with the third sector. Yet initiatives at a local level don't work to prompt national change. For that to happen a national strategy for older people, which embraces housing, health and social care will be crucial.

Without such a systemic approach, the growing pressures on all three areas will continue. The question, as always, is the political appetite for meaningful, far-reaching policy shifts, supported by sufficient funding levels that can not only increase the housing supply across the country, but also greatly enhance the wellbeing of older people going forward. F

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Care for the care workers

The care system only functions thanks to underpaid and undervalued staff. It's time to overhaul how they are treated, argues *Heather Wakefield*

Heather Wakefield is head of local government at UNISON

Constant media headlines signal the undoubted crisis in social care – yet few mention the care workers who are at the heart of our beleaguered care system. Without them, their dedication and their desire to make a difference to the lives of our older and vulnerable citizens, the system would not exist.

This might seem like stating the obvious. Yet behind the wall of silence surrounding the lives of care workers – more than 80 per cent of them women – there are shocking tales to be told and very serious lessons to be learnt about how we transform our care services. One thing is certain – the transformation we need can't be done without a radical new approach to the workforce, women's employment and the care sector as a whole.

This silence about the treatment of our care workers takes place against a background of growing demand, generated by our ageing population. The number of people aged 65 and over is projected to increase from 9.74 million in 2016 to 13.25 million in 2030 – a rise of 36 per cent. Skills for Care estimate that at least 700,000 more care workers will be needed to meet this extra demand. Who will rush to meet it?

Despite the obvious growing demand, successive governments from the 1980s onwards sought to cut the social care budget and have privatised care services. UNISON tracked social care inspections in the late 90s. We found that even where services were deemed 'excellent', the frequent recommendation by the then Social Services Inspectorate was to cut the pay bill. This was generally achieved through privatisation – using spot purchasing which denied TUPE protection to a largely female workforce.

The result of privatisation was the loss of decent pay and conditions, job security and local government pensions. In 1993, 95 per cent of home care services were provided by councils. By 2017, this was a mere 7 per cent. Sixty four per cent of residential care was provided by local authorities in 1979. By 2012, this was just six per cent. The fragmentation of care and the creation of the care 'market' of more than 20,000 organisations today have made it harder for trade unions to maintain membership and negotiate pay and conditions. It has also made it difficult for councils to manage and organise a fragmented service, which drains away up to 20 per cent of the precious care budget in profits to private care providers.

UNISON's 2012 report, Time to Care, revealed the precarious nature of domiciliary care work, zero-hours working, poverty pay, poor conditions of work, isolation and the impact of budget cuts and privatisation on care workers. It also showed that cuts and privatisation have impacted negatively on the quality of care through inadequate time allocated to visits, random allocation of workers to clients and a shocking lack of training.

UNISON's subsequent ethical care and residential care charters – lauded by many – call on care commissioners to place care needs at the heart of both commissioning and employment practice. They require an end to the scandal of 15-minute visits as

well as pay for travel time, sleep-ins and sickness. Zero-hours contracts cannot be used and workers are to be trained 'to the necessary standard to provide a good service'. Pay must be at least at the level of the Living Wage Foundation's real living wage. Yet only around 40 councils and a handful of independent providers have signed up to the ethical care charter because they cannot afford to pay it.

Low pay is endemic to the care sector. This is particularly so in the private and voluntary sectors. The proportion of care workers paid the real living wage (currently £8.75 an hour or £10.20 in London) fell from 26 per cent in 2012 to 10 per cent in February 2018. According to Skills for Care, all care jobs are paid above the National Living Wage. Workers in the private and voluntary sectors earn just £7.76 pence an hour on average, compared to £9.73 in local authorities.

However, these hourly rates do not reflect unpaid travel time between visits. The shocking failure of many employers to pay for travel time – which is required under national minimum wage regulations – generally results in average hourly pay falling below the national living wage and has led to successful legal challenges by UNISON against a number of care providers. Pay slips which are less than transparent simply compound the problem.

Forty seven per cent of domiciliary care workers are on zero-hours contracts – as is 24 per cent of the entire care workforce. UNISON's *Time To Care* report showed how this practice results in lost benefits and mortgages, care workers going hungry and reduced hours when they speak out about poor employment conditions.

The organisation of care work generally assumes the 24-hour availability of care workers, who are largely not adequately compensated for the requirement to work split shifts or sleep-ins. It is not uncommon for home care workers to be required to work three separate shifts in a 24-hour period, with little or no compensation for time spent in cafes or cars between shifts, when returning home is simply not viable. Recent case law establishing the right to pay for 'sleep-ins' has caused great concern among independent and private providers which claim they are not adequately funded or commissioned to pay for sleep-ins.

> Cuts in budgets and privatisation have proved a toxic combination for the largely female care workforce

Cuts in care budgets and privatisation have proved to be a toxic combination, with severe implications for the largely female care workforce. The assumption of women's availability and the lack of value placed on women's time and women's work have reduced complex skills and a vital workforce to bargain basement pay and conditions, with little prospect of adequate training or career progression. Our care services function on the unpaid and undervalued goodwill of women.

This crisis situation demands a radical shift in the mindset of central and local government, social policy thinkers and care providers. Government must start to recast social care as vital social infrastructure, of importance to carers, care users, business and communities. It does after all contribute almost £42bn to the economy. Roads, rail, bridges and housing are all vital. But so is social care. Here are three policy suggestions:

- The Women's Budget Group has estimated that investment of 2 per cent of UK GDP in social care would create 1.5 million 'good' jobs, compared to 750,000 if the same were invested in construction. Almost as many jobs would be created for men as through equivalent investment in construction, while four times as many jobs would be created for women. The impact on the economy of such a public investment boost would be positive, unlike current austerity measures.

- The standards of care and employment in UNISON's ethical care and residential care charters must become the foundation for new statutory employment standards, which should be embedded in contracts and monitored by commissioners. Payslips should be standardised and transparent and HMRC should be required to inspect all providers more vigorously than at present.

- Last but not least – we must get the maximum bang for our public buck. Privatisation means fragmented care services, poor employment conditions and loss of precious public money in the commissioning process and profits. We should look to in-source social care, starting with a requirement of strict financial transparency on all existing private providers, who should be required to be domiciled in the UK for taxation purposes. More of the same just will not do. F

A more generous place

Breaking the impasse in the care funding debate will not be easy. But with a transparent and ambitious offer, change is possible, writes *Caroline Abrahams*

Caroline Abrahams is charity director of Age UK

In recent years we have seen commissions, green papers and white papers all describe the many problems of adult social care along similar lines – but an agreed way forward has proved elusive. 'How to pay for it' is the rock on which the ship usually founders.

Providing dribs and drabs of public money to prevent social care from complete collapse has generally been seen by governments as the best and politically safest approach, but this may be changing. The system is so fragile that the balance of risk has surely shifted towards the requirement to act. If so, a strategy will be needed to break the impasse in the funding debate. What might its components be?

At Age UK we have been talking to older people and their families about these issues and there is other evidence to draw on as well: the Care and Support Alliance survey of people of all ages with care needs in spring 2018; and the May 2018 report from the King's Fund and the Health Foundation, which includes deliberative work carried out by Ipsos Mori.[1]

Overall, these reports suggest a number of issues. Public understanding of how social care is organised and funded is sparse, even among many actually receiving it. Most assume it is part of the NHS and will be free and there for them if they need it. When they realise this is not the case many become angry, feeling that their contract with the state is a sham. It is widely believed that the contributory principle governs how things work: that our taxes and national insurance go into a pot to pay for all our needs as we age. This explains why any proposal to reduce entitlements for older people always generates such fierce opposition – most think they have pre-funded these benefits so removing them is bad faith on the part of the state.

These attitudes and beliefs constitute problem number one for any government seeking to persuade the country of the need to raise more money from them to fund decent social care.

Once people understand how social care is funded and how vital it is for millions of older and disabled people they want to improve it – for themselves, their loved ones and indeed for the population as a whole.

The focus groups Age UK carried out this year found that older people would be prepared to pay more, if they could afford it and the sum was reasonable, but only in exchange for better services. For example, time and time again those in receipt of care at home complained of visits cut short by carers in a hurry, leading to poor quality, dehumanising care. They did not blame the paid carers but the system in which they were working.

Yet the case for more funding for social care is often framed by politicians as driven by the need to meet the care needs of the far greater numbers of older people we will have in future, as our society ages. So this is problem number two: people might accept that they need to contribute more to help fund a better care system, but they want it today, not in 10 years' time.

These and other research exercises consistently find some interest in the idea of a 'cap' on how much anyone has to pay for care, certainly among those with assets. However, the extent of this interest is not enough to convince them that it would be worth contributing substantially more.

> Any new settlement for social care has to be big enough to allow significantly more people to receive care

The third problem is that we know that well in excess of a million older people and disabled adults currently have some need for care that is not being met. This is in large part because the state-funded system has shrunk as a result of public sector austerity. So any new settlement for social care has to be big enough to allow significantly more people to receive care in the short as well as the medium term, not just to improve the care for those already getting it.

1 Why Call it Care When No one Cares? Age UK, March 2018; Care and support Alliance survey, May 2018; A Fork in the Road: Next Steps for Social Care Funding Reform, the Health Foundation and the King's Fund, May 2018

The hardest question to get people to engage with is 'how should we pay for a better and more sustainable social care system?' Naturally, no one really wants to pay any more at all; however, when push comes to shove all these projects found a preference for the money to come from general taxation or national insurance, plus perhaps some form of tax on wealth, such as a charge on estates after death. Older people and families Age UK talked to did not instantly reject the notion of a 5 per cent levy across the board, following death, because they felt it wouldn't entirely ruin anyone and would be fair.

In contrast, the idea of losing their home to pay for care incensed many people in all these recent studies: they felt they had worked hard for it and it was wrong for the state to take it away, if they were unfortunate enough to need a lot of expensive care in old age. Of course, this is effectively what happens to some people today, but few realise it. Therefore, they have mentally already 'banked' a policy advance that governments may wish to pursue, but which will need quite a lot more public money to bring about.

It is also notable that the overwhelming majority of people who took part in all these various research projects wanted any extra money raised for social care to be ring-fenced so that they knew it was really going for that purpose.

It is far easier therefore to describe the funding debate impasse than to overcome it – and there are other barriers I have not even touched on, including the desirability, and difficulty, of achieving any kind of cross-party consensus. However, before we succumb to despair, it is worth reflecting on some of the insights these projects provide into what a successful offer to the public might look like.

Government inaction for a generation means that social care is now in a terrible state; making it fit for purpose for those who need it today, let alone for greater numbers tomorrow, will therefore cost a lot of public money – several billion more a year at least, if not more. This sounds a lot and it is, but it is not impossibly large. It means some big funding interventions will be required like those outlined above.

Talking to people of all ages about social care makes me and many others believe that it will be much easier to 'sell' a more ambitious offer on social care which is easy to understand, than tinkering around at the margins of the current, deeply complex and often unfair system and achieving only minor improvements. Yes, we are all likely to have to put our hands in our pockets in various ways but at least the public would see they were getting something worthwhile in return. Only by jumping to a different, simpler and more generous place will it be possible, I believe, to win public acceptance and support.

A Fork in the Road referenced above concludes that the Scottish approach of free personal care at the point of use costs not a lot more than the floor and cap put forward by the Conservatives at the last election. It is not a panacea in Scotland and has not solved every problem facing social care there, but it is politically very popular. The think tanks believe it is one of the options worthy of serious consideration in England too and, for all the reasons I have explained here, I think they are right. F

A juggling act

Millions of unpaid carers struggle with the toll caring takes on their health and finances. A reformed care system must give them the support they need, writes *Heléna Herklots*

Heléna Herklots is chief executive of Carers UK

All of us, at some stage in our lives, will be providing unpaid care for someone, or will need that care ourselves. In the UK today, there are 6.5 million unpaid carers and, of those, 1.2 million are older people in England. For those aged 85 and over, 44 per cent of women and 23 per cent of men are receiving unpaid care. The fastest growing group of carers are people over 85, often dealing with long-term health issues themselves.

In public and political discussions about care and support, it is too often overlooked that most care is provided not by the NHS and social care services, but by family and friends. Worse, some politicians and commentators suggest that the current social care crisis exists because families don't care enough, whereas the evidence tells us that families are caring more – the 16.5 per cent rise since 2001 in the number of people providing unpaid care is faster than the growth in the population as a whole. We can cost this too – the value of the unpaid care is £132bn – around the cost of a second NHS.

It is surely something to be celebrated that we are a caring society. We need an approach to care, support and wellbeing in old age that recognises this, and that supports it. For this to happen, there needs to be a coherent public policy framework that includes employment as well as care, health, housing and social security.

What needs fixing?

The underfunding and lack of social care support manifests itself in many different ways in the lives and experiences of carers. For example, in the Carers UK State of Caring survey in 2017 we found that 40 per cent had not had a day off for more than a year, and 25 per cent for 5 years. The physical and mental health effects of this are huge, and it is one of the reasons why the health of carers is worse than non-carers.

The reasons that carers can't get a break include not only the availability of respite, but also concerns about the quality of what is available. As one carer put it: "I would never dare to take a break away from caring as the standard of care cannot be relied upon. The potential risk to the life of the person I care for is too scary to contemplate."

> Too many carers have to give up work to care, with serious consequences for their finances, affecting their income in retirement too

Three million people in the UK are juggling paid work and unpaid care, and this number is increasing. The new reality is that more and more of us will be caring for an older relative whilst working, and the world of work must change to accommodate this. In the same way that the issue of working parents came into the mainstream of employment policy and practice, backed by enforceable legal rights, so too must the issue of caring. Too many carers have to give up work to care, with serious consequences for their finances, affecting not just their current circumstances but their income in retirement too.

The impact of caring on finances in later life was highlighted by the government's independent reviewer of the state pension age, John Cridland. If we are to tackle the poverty faced by many carers in later life, we must look at workplace support and also at the very low level of financial support for those carers with limited or no ability to work alongside caring. Carer's Allowance, the main benefit for carers, is the lowest of its kind and many carers who receive the state pension can't receive the full amount as well as their pension.

More recognition and support from the NHS is vital. Despite the reliance of the NHS on carers, and some welcome developments in how the NHS recognises and supports carers, for example through the NHS England commitment to carers programme, for many carers their experience is of a health service that does not recognise their role, or if it does, it is not matched with support. When asked if their GP knows they are a carer, more than 68 per cent of carers said that their GP did know but doesn't do anything different as a result. Only 9 per cent said that their GP did know and offers them extra support with their caring role.

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We need a 'carer-friendly' NHS that identifies and supports carers – throughout the caring journey.

Caring is costly. It can be costly to your health and well-being; costly to your employment opportunities; and have a significant impact on your income and your pension.

What works well?

We need a combination of practical measures, cultural change, increased and sustained funding, and the backing of legal rights.

Some of the practical measures that can be taken now are low or no cost, and can bring economic benefits. For example, an employer introducing a carers policy with paid care leave can reduce absenteeism, improve productivity, and improve retention. So it has benefits for the carer, and the employer. It also has benefits for the wider economy with more carers being able to stay in work. Introducing carer-friendly employment policies and practice can help with staff retention in the NHS and in social care too.

Increasing the identification of carers is a pre-requisite to recognition and improving support. 'Carer passports' can help with this, and can be applied in health and care settings, and in workplaces. They are a way of carers being identified and supported, and mean that carers do not have to repeatedly explain their circumstances.

The right technology can help make caring easier. It can help someone live independently for longer, and can give the carer 'peace of mind' when they are not there. Simple devices and apps can make a difference, and need to be available and affordable.

We know that caring can be an isolating experience; it can feel as if your world shrinks as you focus on the care of another, sometimes to the detriment of your own quality of life and well-being. Peer support, such as Carers UK's online forum, is an important way of breaking this isolation and there needs to be a range of local and national services and support for carers, and a vibrant voluntary sector to innovate and provide these services.

Being a carer is not something we plan for, and when we take on caring responsibilities we can face a bewildering range of systems and services, eligibilities and assessments. Having the right information, advice and support to navigate this is crucial. Despite the provisions in legislation for example in the Care Act 2014, the reality is that many carers do not get the information and advice that they need. Investing in information and advice at local and national levels, so that carers know their rights and entitlements, but also get advice about being a carer, can make the caring experience more positive and manageable, and help prevent some of the detrimental impacts that caring can have.

Making it happen

Although many improvements can be made through changing practice and culture, they need to be matched with the right legislative framework, and a long-term investment in support. Specific recommendations are to:

- Introduce a legal right to paid care leave, so that people can juggle work and care.
- Introduce a legal duty on the NHS to identify and support carers, to support carers health and wellbeing.
- Put in place a sustainable funding system for social care so that respite services and information and advice are available for carers.
- Improve financial support for carers including by enhancing support for full-time carers close to state pension age through a carer's pension so that they don't experience poverty in retirement due to their caring responsibilities.

With these improvements to carers' rights, we will be able to create a society that respects, values and support carers. F

Breaking down barriers

Integrating health and social care and offering good specialist services are crucial in ensuring people stay independent for longer, as *Eileen Burns* explains

Eileen Burns is president of the British Geriatrics Society

Integrated health and social care is essential for older people for whom the current distinction between the two sectors is an illogical barrier to good care. Even those who work in health and social care know just how complex it can be to navigate between the two sectors, should they have need to support their own family members through this process. All recent governments have espoused the integration of health and care, and it should therefore be at the forefront when we consider changes to the way care for older people is funded.

Access to good public health services, specialist support and restorative treatment – that is, rehabilitation and 'reablement' – and good, patient-centred end of life care, delivered in the place the person wishes to be, are key to maximising older people's independence and quality of life and thus reducing their dependence on social care. There are a number of measures to help achieve this.

Wider pathways

First (not surprisingly) we know that helping older people to maximise their health can reduce the demand for health and care services. The importance of public health measures is therefore clear.

Fit and active older people need public health advice and support in order to stay well for as long as possible. Good (evidence based) advice is to avoid smoking, consume alcohol only moderately, remain active and engaged in society, avoid loneliness, eat well, and maintain normal healthy weight. Adequate funding of the voluntary sector to facilitate the provision of exercise classes, walking groups, social activities such as lunch clubs or art and activity groups is both beneficial and cost-effective.

Older people with single long-term conditions (such as diabetes, heart disease etc) – as well as their families and carers – should be advised to follow a healthy lifestyle, and offered guidance to ensure they are able to manage their condition as well as possible to reduce the risk of deterioration and crisis.

Investment in these preventative public health measures, promoting wellbeing and avoiding medicalisation, can have a positive impact on health outcomes for older people, and therefore their use of both health and social care services. But the extent to which they may do so is dependent on wider socio-economic factors, with clear evidence that health status is linked to economic status.

The identification and assessment of frailty among older people, specifically comprehensive geriatric assessment (CGA), is a key part of promoting better health for older people. CGA is a multidimensional process of assessment and care planning based on those issues which the older person, and often their families, have identified as most important to them. And it has a robust evidence base for effectiveness. Patients who have received CGA are 20 times more likely to be alive and living in their own homes 12 months after the assessment than those who have received 'standard' care.

As frailty advances, access to high-quality palliative and end of life care is essential. It is important to recognise that 'frailty' used in this context is indicative of a specific condition associated with increased susceptibility to deterioration in response to a relatively minor issue. For example, a urinary tract infection in a young woman with good health might cause discomfort and some distress but would not impact on her ability to self-care. But a frail older person might present with a fall, delirium or reduced mobility in response to such an infection.

Older people's level of frailty can be identified using a number of different assessment processes. Some of these are time-consuming and too cumbersome for routine use. However, the development of an electronic tool to identify frailty, using components coded in the primary care record kept by the GP, allows easy categorisation of levels of frailty. This electronic measure – the electronic frailty index – offers the opportunity for proactive care in a more targeted way than has previously been possible.

The evidence for the effectiveness of a comprehensive geriatric assessment is strongest in an acute hospital setting, within specialist units focusing on the care of older people. However, the development of methods of identifying frailty may allow the targeting of proactive CGA for the frailest patients outside of hospital, which may have a positive impact on their need for both health and social care.

Promoting better health in old age should mean avoiding the 'medicalisation' of old age where possible. But we need to recognise that most of the care needs of older people are as a result of a medical

condition, for example, a stroke, arthritis, dementia. Providing the best quality medical care and offering the opportunity for rehabilitation are crucial in reducing older people's care needs. And while there is already strong support for patient-centred care, we need to move further and more proactively towards a model of care that is based on the expressed wishes of older people themselves. This will require some financial investment, though it may be in relatively low-cost interventions that have a big impact, for example, in avoiding care home admissions.

One of the current challenges is that when an older person experiences a crisis in the context of their frailty, such as a fall, an episode of delirium or reduced mobility, the only consistent response available to them and their carers is a medical one. Frequently the crisis may be precipitated by a relatively minor medical issue which could be managed without hospital admission, but in many parts of the country no response other than a medical one is available. There are isolated examples of integrated health and care teams which can provide a community-based urgent care response but they are few and far between. Expansion of this model of care may allow fewer patients to be admitted to hospital.

An ongoing randomised controlled trial is looking at the provision of 'hospital at home' for patients with an acute frailty syndrome. The service must include access to diagnostics and a doctor (or advanced nurse practitioner with diagnostic skills) who has expertise in the care of older people, and care and support to allow management at home. An interim analysis suggests that outcomes for patients managed with 'hospital at home' are as good as those admitted to hospital. Crucially, those randomised to care at home were more likely to be living at home six months later. If confirmed by the full trial these findings would be hugely important for the health and care system. Previous studies of services to allow patients to be discharged from hospital earlier than would traditionally have been the case have consistently shown a reduced likelihood of being in a care home after six months. It is therefore imperative to enhance community services designed to avoid or shorten acute hospital care for frail older people.

Ultimately, however, most frail older patients will require health and social care before their death and in many cases they will have one or more illnesses of sufficient severity to require hospital admission. Hence, the relative underfunding of the NHS and absolute defunding of social care must be addressed.

Individuals' perspective

The Care Quality Commission recently reviewed 'integrated care' and found that whilst there was widespread commitment to making it work, there were still many organisational barriers that made it difficult for services to identify older people at risk of deterioration or of an unplanned emergency admission to hospital. It also found the examples of joint working in delivering health and social care were often inconsistent and short-term. Crucially, the commission found that older people were not routinely involved in decision-making. Frequently older people and their families or carers did not receive clear information about how their health and social care would be coordinated if there were changes in their circumstances or if there were an unplanned admission to hospital.

The British Geriatrics Society and the Royal College of General Practitioners jointly published a report in 2016 on integrated care for older people with frailty which provides examples of innovative approaches in practice. Some of the key factors in successful joint working which the report identified include: continuity of care; collaboration and communication; multidisciplinary working and professional development.

A wider reablement offer

Geriatricians know that reablement services are valuable in helping to facilitate hospital discharge for older people.

Yet the division between reablement and intermediate care is somewhat arbitrary. Both services should be made more widely available – and the integration of the two which has happened in some parts of England should be more widespread.

The evidence base for the effectiveness of intermediate care is robust, with patients transferred for rehabilitation experiencing better recovery than those remaining in a district general hospital. However, if patients were delayed in hospital, waiting for bed-based intermediate care for more than two days that benefit was negated. Thus, capacity in intermediate care needs to be adequate to allow timely transfer. Recent audits of the service have suggested that current provision falls far short.

> Geriatricians want to see health and social care interact together for the benefit of older people

Although there have been few randomised controlled trials of social care delivered reablement, evidence suggests that compared with 'standard home care', reablement resulted in better health-related quality of life for people receiving the service.

The way forward

The benefits of comprehensive geriatric assessment on health outcomes for older people with frailty are well-evidenced. There is also some evidence that the use of a frailty assessment tool is effective in proactively planning and delivering health and care for older people. It may be useful now to carry out some economic modelling of the benefits of more extensive use of comprehensive assessment, and of wider early identification of frailty. This is especially important given the evidence around avoiding care home placements, an outcome which most older people regard as unwelcome and which is expensive both for individuals and for the care system.

Geriatricians want to see health and social care interact together for the benefit of older people. We recommend a method of funding which is equitable across the generations and does not place the burden solely on older people themselves. All recent governments have espoused integration of health and care, and therefore a method of funding which moves the system towards that goal, rather than further away from it, needs to be found. **F**

A question of trust

We need to ensure communities can plan the right services for the older people in their area. Devolution should help, if only it were properly resourced, as *Jim McMahon* explains

Jim McMahon is Labour MP for Oldham West and Royton and shadow minister for devolution

A nation should be judged on how it invests in the next generation, and how it looks after those who have contributed all their lives to our country. On both tests the government has consistently failed.

Earlier this year, the Secretary of State for Health announced a forthcoming green paper which will lay out plans to tackle the country's escalating adult social care crisis. A decade on from the financial crisis and after eight hard years of cuts to local authorities, there has been little action on putting in place a foundation of fair funding for the future. Meanwhile, there has been at best a half-hearted effort to devolve and forge integrated health provision at a city and local level. The green paper must address a range of key challenges.

Any discussion on the future of adult social care normally majors around talking about the cash. How much money is needed? Where is the funding going to come from? But what my experience when I was leader of Oldham Council taught me was that it was all very well asking the government for money but the reality of the situation is: first that councils can't continue to be left in a situation where they are at the mercy of a government controlling the purse strings; and second, the challenges to adult social care services are so profound, that continuing to pour money into the same tired old paradigm of provision is not sustainable.

Yes, we do need a properly funded social care system. Time and again Labour has demanded an answer from the government frontbenches on its cuts to councils and its inertia on creating a sustainable fair funding system for councils to operate under.

We know the challenges are great too. Demand for social care provision, like health, is driving up the financial cost – and the government seems caught in the headlights. To illustrate the scale of the challenge if every older person currently waiting to be discharged from hospital into care was in an ambulance, bumper-to-bumper that line would stretch around the coastline of mainland Britain.

The cracks run deep into the social care workforce too where there is a shocking turnover and vacancy rate. It is estimated that by 2030 we will need 700,000 additional social care workers. Where poor workforce retention is concerned, cause and effect are at play. The pressures and demands on the system as a whole ultimately fall on the shoulders of the frontline workers.

But we must not continue to accept the often poor treatment of care workers who are usually paid much less than the real living wage. How we meet today's demand and prepare for increasing demand in the future is vital. It is telling that where the highest apprenticeship levy payment is £27,000, social care attracts just £3,000.

What can be done to stem the crisis, and turn this situation around? There will be different responses in different localities. But we also need a government that can show leadership, and offer a bolder vision to empower councils to do what is right for their area.

Councils are already proving their worth – and there are some key areas where they can take the lead. Despite the overwhelming pressures across all services areas, councils are innovating to meet the challenges to social care provision head-on. Some, like Derbyshire County Council, are putting in place plans for their own integrated approach to health and social care to support residents who want to maintain their independence. South Tyneside, an area with a rapidly ageing population, is also integrating health and social care services tailored to meet the needs of its older residents. There, a dementia unit has been built on the grounds of the district hospital providing residential and day care along with respite and rehabilitation services.

A question that the King's Fund has asked is whether our market-based system of social care provision can stand up to this growing demand. To do so, it must manage current demand, but also like any capable business it must be able to guarantee its future provision by assessing the scale of demand in the decades to come. A key risk with the market-led model of (largely) independent not-for-profit and private sector care providers – which have replaced traditional local authority provision – is that they will not be able to guarantee provision at a cost that is fair to the purchaser, whether that be the NHS, councils or private payers.

Demand management is key, and councils play a key role here. The King's Fund rightly highlights that ahead of the green paper the government has been talking a lot about the growing demand for social care services, but paying little attention to how we can influence and control that demand now and in the future. Central to this is not only how we actually measure that future demand, but also how we incentivise activities that reduce demand in the first place. Some councils are adopting a greater preventative approach. Southwark, for example, has been recognised by the World Health Organisation for creating an age-friendly borough, making it a safer, happier and healthier place for older residents to live. Steps taken include free swim and gym facilities for over 60s, becoming a dementia-friendly borough, and UNISON's ethical care charter, which guarantees the London living wage and paid travel time for all home care workers.

We need a bold vision at government level – a vision backed up with devolved powers and finance to local authorities. Action is being taken in some areas, but it is still too small scale to determine success. But in the longer term experiments with devolution and integration of health and social care provision could hold the key to tackling the challenges the country faces.

There has been a small shift in the government's thinking on how health and social care can be delivered together. Along with powers over housing, skills and transport, the 'Devo Manc' deal between the Treasury and Greater Manchester has paved the way for the councils and NHS in Greater Manchester to take control of the region's £6bn health and social care budget, albeit with a £2bn funding gap to accompany it.

The inclusion of health within devolution deals could be seen as an extension to the policy direction which has been moving us towards more place-based commissioning and decision-making. Recent reforms have also seen population-based budgets now split between clinical commissioning groups, NHS England and local authorities. Most of NHS, public health and social care commissioning is already devolved to local organisations.

There is no blueprint for devolution let alone a proper integration of health and social care. These problems are compounded by the lack of extra money

Yet despite all the trumpeting from the government, Greater Manchester councils still do not have their hands on the financial levers which would allow them to fund social care adequately in the long term. Nor do they have the resources to tackle some

of the drivers of increased demand for health and social care among their elderly populations, for example social and economic inequality. In fact the government is undermining efforts to do so by hollowing out our civic infrastructure which has been disproportionately targeted at local government level, which is the foundation devolution now rests upon.

There is no blueprint for devolution, let alone a plan for proper integration of health and social care. These problems are compounded by the lack of extra money. Only £60m extra has been put aside for service reform in Greater Manchester. This when all the evidence suggests that integrated care delivers better outcomes, but not necessarily savings.

The King's Fund has specifically highlighted meddling from Whitehall as a principle risk to health devolution. In fact, as things stand, devolution is a misnomer. The plans in Greater Manchester for integrated health and social care are largely taking place within the framework of existing legislation. A lot of NHS responsibilities still sit with Whitehall.

Integration of key services, such as social care, housing and benefits with health is key. Councils must be trusted to deliver this model, and this trust must be backed up with financial powers too. **F**

Councils in control

Local authorities are on the frontline of the care crisis. The next Labour government must make it easier for them to support those who need it most, writes *Linda Thomas*

Councillor Linda Thomas is leader of Bolton Council and Labour lead member on the Local Government Association's community wellbeing board

Successive governments have been warned time and time again that shifting demographics are storing up a ticking time bomb in future demand for care for older people. People are living longer, and more people are living with long-term and complex chronic health conditions that require managing through care. And while the UK may not yet be in the same position as Japan – where more nappies for adults are now sold than for babies – we are certainly heading that way.

Social care continues to receive increased media attention and is subject to frequent public debate. But despite many years of intensive lobbying by politicians, charities, and other interested parties, this government continues to prevaricate, offering sticking plaster solutions.

Since 2010, councils have dealt with a £6bn funding gap in adult social care services. This has been met through £3.4bn of savings to adult social care and £2.6bn taken from additional savings to other services. The government's one-off investment of £2bn over three years runs out in 2020, and allowing councils to levy an extra three per cent precept on council tax simply shifts the burden of a national crisis onto local residents. Council tax rises also raise very little in the deprived areas that require extra money most.

The new adult social care support grant introduced in 2018 is not new money and was instead created from savings in the New Homes Bonus – it is literally a rebadging of funding already promised to councils – and its creation actually leaves some councils worse off overall as they lose more in New Homes Bonus payments than they gain in grant. Even after these changes, adult social care still faces an immediate and annually recurring gap of £1.3bn, which is the difference between what care providers say they need and what councils currently pay – and as a result there will be an overall funding gap of £2.2bn by 2020.

So it will be up to the next Labour government to solve both the current social care crisis and also to find a sensible approach to meeting the longer term challenge. Ensuring our most vulnerable fellow citizens receive the care and support they need to live in dignity and comfort is fundamental to our Labour values.

> Funding councils properly would create immediate better outcomes for people who need support

There is no escaping the fact that what is most desperately needed from the next Labour government is a serious injection of funding – starting with meeting the immediate gap of £2.2bn. Funding councils properly would create immediate better outcomes for people who need support, and would produce a knock-on saving for acute costs in the NHS.

The Better Care Fund was meant to be a catalyst to encourage and formalise joint commissioning of services, but while there are examples of very good practice, these are not uniform and depend very much on trust and good relationships between local government and NHS colleagues.

With new funding, councils will be able to implement new ways of working. The acute sector is still finding it nigh on impossible to close beds, which is where the savings to implement integration were meant to arise. Even models such as health devolution in Greater Manchester with transformation funding are struggling under financial pressures.

Adequate funding would also help find the crucial missing piece of the jigsaw: homecare. Local government is finding it increasingly difficult to commission homecare at rates that allow providers to pay wages that are commensurate to the value of caring for our most vulnerable people, or to provide the level of care that service users really need.

Many Labour councils have prioritised addressing this challenge by adopting UNISON's ethical care charter, detailed in Heather Wakefield's chapter in this collection, designed to ensure both decent care for vulnerable adults and good employment standards for care workers. Councils that have signed up agree to pay at least the real living wage to all care workers, to schedule care visits according to the needs of the individual – with care workers given

enough time to provide the care needed – and pay care workers for travel time.

Other measures include offering homecare workers regular training and ensuring providers have clear and accountable procedures for care workers to raise concerns about the wellbeing of the people they are caring for.

Care workers should be seen as an integral part of neighbourhood teams, working closely with all professionals. By encouraging recruitment of care workers from the locality, benefits would accrue from not having to pay for long periods of travelling time. And we could improve pathways into other health work from initially becoming a care worker, which should be on offer to make it an attractive proposition for those who want this opportunity. Greater Manchester's Care 2020 model would progress us well down this route.

Relieving the terrible cost pressures on social care would allow councils to focus on what experts know can make the biggest difference to the looming cost pressures of demographic change – early intervention and prevention. If low-level needs are prevented (or even delayed) from developing into more serious or acute needs then both the individual and the state benefits.

Truly effective interventions are locally designed – preventative early intervention will not work if one attempts to impose it remotely from Whitehall, or even through the highly centralised and bureaucratic NHS. This is why it is vital that local councils retain control of social care.

One suggestion would be to set the eligibility criteria, allowing people to choose the sort of care and support they require, and then for it to be free. This is a truly person-centred approach and the savings in the system would come from no longer requiring an army of commissioners to dictate how many minutes and hours an individual should have – and it would most certainly crack that thorny issue of 15-minute visits. This system is operated successfully abroad and is worthy of consideration by a Labour government.

Integration of health and social care systems should be on the basis of the NHS and local government being equal partners. When a health and care plan is agreed on the basis of evidence from a joint needs assessment, the spending on that plan should have a mechanism where it is jointly agreed, implemented, and monitored.

For the first time ever, this would make health and social care governance truly accountable. In order to do this, the Health and Social Care Act 2012 would need reversing, which is also important if we are to end the private sector infiltration of our health system.

As a Labour party our whole philosophy is encapsulated in our proudest achievement – the introduction 70 years ago of a National Health Service that guarantees all citizens, irrespective of their circumstance, access to free health care at the point of need. It should be the mission of the next Labour government to establish another equally sustainable and iconic system, that will also endure for 70 years or more – and that offers a further guarantee that all citizens, irrespective of their circumstance, will have equal access to the care and support they need to live in comfort and dignity for the rest of their lives. **F**

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