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BOARD PAPER - NHS ENGLAND

Title:
Adult social care – the service and its role in an integrated system

INVITE PAPER

From:
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Purpose of Paper:

- To provide an overview of adult social care in England
- To set out adult social care's offer in an integrated system
- To prompt discussion on how local government and the NHS can best work together

The Board is invited to:

- Note the scale and reach of adult social care and the pressures facing the system (paragraphs 11 to 49).
- Comment on the adult social care offer as articulated in the report (paragraphs 50 to 56).
- Offer views on how the NHS can best work with local government to advance shared objectives (paragraphs 57 to 67). Specifically:
    i. How can our respective organisations better and more consistently engage?
    ii. What should joint working and co-production between our respective organisations look like?
    iii. How can we best identify and resolve joint workforce issues facing the system?
    iv. How can we fast-track joint health and care personal budgets?
    v. How can we work together on the sustainability of the nursing home market across the country?
    vi. How might we work jointly to identify opportunities for developing sector-led methodologies in areas where we deliver jointly?

Executive summary

1. Adult social care responds to a wide range of needs. It provides care, support and safeguards for those people in our communities who have the highest level of need and for their carers. And it helps many others to live as independently as possible through universal wellbeing services. It is a vital service in its own right but also vital in terms of its links with many other local government services that contribute to an individual's wellbeing such as housing, public health, transport and leisure.

2. The service is under tremendous financial pressure. The impacts of this are significant and are being felt amongst providers, the workforce, and service users in terms of service availability and quality. The immediate future will be equally strained. Against (and despite) this backdrop there is a continued drive towards greater personalisation of services with users much more in control of their own outcomes and how these are to be achieved.

3. Adult social care is also in a period of significant change. The service is about to implement a major set of reforms as the Care Act goes lives from April 2015 and at the same time the system is committed to shifting its focus from crisis treatment to prevention and early intervention.

4. These changes require clear and strong local leadership and new governance arrangements – particularly health and wellbeing boards – are bedding down and adapting to a challenging landscape.

5. Local government has a strong track record of working with its health partners. At a time of serious pressure and change within the system, and an associated need to transform services to maximise outcomes for individuals and value for money for the public purse, this relationship is more important than ever.

6. The benefits of adult social care's contribution to an integrated system accrue to both individuals and the NHS. For the former the service provides an increasingly personalised response that is geared towards delaying or avoiding the onset of more difficult and costly conditions. Where longer-term support is needed the service is focused on person-centred, consistent and co-ordinated care. For the latter the service helps alleviate demand pressures, allowing a focus on priority patients. The relationship is reciprocal, of course; NHS and clinical practice helps to delay the need for long-term care and support.

7. If we are to realise the aspiration of an overall system that helps support a national population to be healthier, more independent, out of hospital, and pursuing their ambitions in their communities, then we must go further. This must include protection of adult social care funding and decisions about the next steps for the Better Care Fund. Going further will only succeed if we work together; below are some discussion questions to consider how we might do this:

    a) How can our respective organisations better and more consistently engage?
    b) What should joint working and co-production between our respective organisations look like?
    c) How can we best identify and resolve joint workforce issues facing the system?
    d) How can we fast-track joint health and care personal budgets?

e) How can we work together on the sustainability of the nursing home market across the country?
f) How might we work jointly to identify opportunities for developing sector-led methodologies in areas where we deliver jointly?

Purpose and context

8. Local government has a strong track record of working with its health partners. Financial pressure and the need for better quality make this relationship more important than ever. Both the Local Government Association (LGA) and the Association of Directors of Adult Social Services in England (ADASS) are committed to continuing the proven collaboration between adult social care and health; both locally in our work with councils and the local NHS, and nationally with NHS England and other health partners.

9. A successful long-term partnership must be built on a mutual understanding of what we each do and the context in which we are each operating. The first purpose of this paper is therefore to provide an overview of adult social care in England. The paper then articulates social care's 'offer' in an integrated system. This can become an important enabler for NHS England in delivering its Five Year Forward View vision, much of which resonates with what the LGA and ADASS have called for in terms of securing meaningful transformation of services.

10. For local government, working together to bring about real change is essential, not just desirable. A failure to collaborate, and equally a failure to present a shared position in the run up to the General Election and beyond, will only exacerbate existing pressures and fragment the system further.

Adult social care: an overview

The scale of the operation

11. Social care is rooted in the diversity of local government, which has responsibility for a range of other services which help people stay independent and healthy. Councils have a critical leadership role in public health, as highlighted in the NHS Five Year Forward View, and in many other areas such as support to carers, engagement with employers, promoting dementia friendly communities, and through a variety of functions such as planning, design, housing, trading standards and community safety. As the composition of our communities changes, it is local government that is ensuring those communities are as supportive as possible to older people, working age adults with disabilities, and people with long-term conditions. This is important for people – residents – who are fundamentally familiar with the local authority boundaries in which the live.

12. Social care provides care, support and safeguards for those people in our communities who have the highest level of need and for their carers. Good care and support transforms lives, helping people to live good lives, or the best they can, in a variety of circumstances. It enhances health and wellbeing, increasing independence, choice and control.

13. Social care is a vital ‘connector’ to other public services, especially the NHS but also local housing and community services. It works in partnership with community groups, voluntary and private providers and organisations that represent people who use services.

14. Adult social care touches the lives of millions of people. Almost one fifth of the adult population of England has experience of the service, be that as a recipient of services, as unpaid informal carers, or as part of the paid workforce.

- Recipients of services:
  - The total number of people receiving services in 2013/14 was 1.3 million. Of these, just over 1 million received community services, just over 200,000 received residential care, and 85,000 received nursing care.
  - The number of contacts from new clients in 2013/14 was 2.2 million. Of these, just under 1 million required a further assessment or commissioning of on-going services.

- Workforce:
  - An estimated 17,300 organisations were involved in providing or organising adult social care in England as of 2013.
  - Around 70,000 of the 214,000 adults, older people and carers in receipt of direct payments are directly employing their own staff.
  - As of September 2014 there were just over 130,000 council adult social services jobs in England.
  - At 1.45 million the total adult social care workforce is bigger than the workforce of the NHS.

- Carers:
  - As of 2011 there were 5.4 million informal carers in England, up from 4.9 million in 2001.
  - 1.4 million carers provide over 50 hours of unpaid care per week.
  - The value of unpaid care is worth an estimated £119 billion per year.

15. Social care contributes to economic growth as well as meeting social needs. Most care providers are businesses that form a sizeable chunk of the local economy in many places. It contributes as much as £43 billion to the national economy and at 1.5 million the total adult social care workforce is bigger than the workforce of the NHS.

16. Historically councils have had the discretion to decide which needs are ‘eligible needs’ – ie the level of need at which an individual qualifies for receiving care and support. This system was established partly in response to concerns of a ‘postcode lottery’ and is based on four thresholds: ‘low’, ‘moderate’, ‘substantial’ and ‘critical’. The vast majority of councils have operated at ‘substantial’ or ‘critical’ in recent years. Under the Care Act local discretion in deciding eligibility will be replaced with a national (minimum) eligibility threshold. This is broadly equivalent to the current ‘substantial’ threshold.

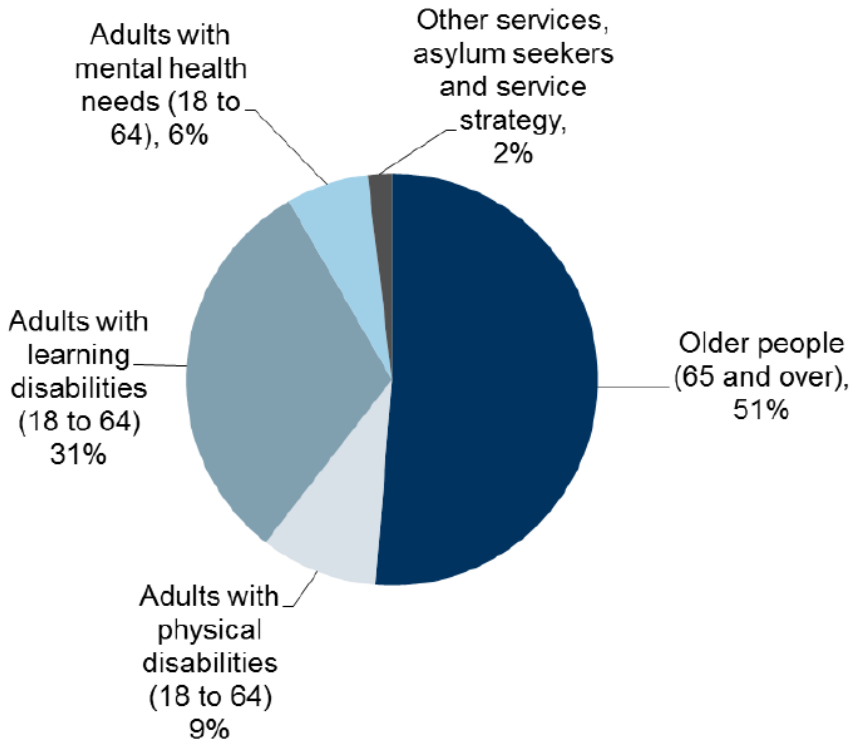
17. In addition to those people who come into contact with local government’s adult social care services there is a further – and significant – group of ‘self-funders’ who arrange and pay for care themselves. Laing and Buisson (one of the leading sources of healthcare market intelligence) estimate the total size of the self-funded care home market for older people alone at £4.9 billion a year.

18. Local studies conclude that social care service users account for a substantial majority of NHS activity and expenditure. This cements the relationship between health and social care and the need to work together to tackle the issues before the system overall. This is backed up by further by NHS England's Five Year Forward View, the Greater Manchester agreement, the experience of dealing with winter pressures, and other key developments; we can only manage on-going pressures – and deal with austerity – by working together.

Funding and expenditure

19. Adult social care involves both public and private spending. Unlike healthcare, adult social care services are subject to financial means-testing and charging. Net expenditure (net of fees and charges) stood at £14.6 billion in 2013/14 – approximately 35 per cent of councils' total spending and the biggest single budget that councils control. Gross expenditure (including fees and charges) stood at £17.3 billion in2013/14. In addition to public spending individuals spend at least £10 billion of their own money on care services, independent of adult social care services. Nearly half of all care home fees are met by individuals with their own money, for example.

20. The chart below illustrates the proportion of gross current expenditure (£17.3 billion) in 2013-14 by service and client type.



Pressures

21. Local government has faced unprecedented cuts over the last four years that have impacted dramatically on adult social care and its capacity to deliver. LGA analysis shows that during the life of this Parliament core funding for local government will have reduced by 40 per cent in real terms.

22. As a result of these cuts adult social care is under extreme financial pressure. Over the course of the 2010 Spending Review period adult social care spending has been kept under control through a mix of: departmental budget savings of 26 per cent (the equivalent of £3.53 billion); the NHS transfer; and at least £900 million 'cross-subsidy' savings from other council services. This figure is expected to increase by a further £1.1 billion in 2015/16.

23. Councils have protected adult social care during this time. The service now accounts for an increasing proportion of council spending; 35 per cent in 2014/15 compared to 30 per cent in 2010/11.

24. The short-term will be extremely difficult. The scope for further savings is now much reduced and at the same time there are real concerns about the financial implications of both the Care Act and changes to Deprivation of Liberty Safeguards (DoLS). The Care Act may be underfunded by as much as £50 million in 2015/16 alone, and changes to the legal basis of DoLS is adding additional in-year and on-going unfunded costs of at least £98 million.

25. Demographic change has exacerbated pressures and has added costs of about 3 per cent of the service budget for each of the last four years. This equates to approximately £400 million per year and councils have funded, on average, just over 80 per cent of the pressure.

26. The LGA estimates that the overall funding gap for local government will add up to £12.4 billion by the end of 2019/20. Projections show that the funding gap for adult social care will reach £4.3 billion or 29.4 per cent of net adult social care budgets in 2019/20. This assumes the service makes efficiency savings of 1.5 per cent in 2015/16, tapering to 1 per cent thereafter, and sees a net benefit of £500 million from the continuation of the Better Care Fund. These efficiency savings may seem low but in the context of what has gone before they are not. Between 2010/11 and 2013/14 councils made savings of £10 billion, primarily by finding efficiency savings from existing services. Within this adult social care made savings of 26 per cent, the equivalent of more than £3.5 billion. The very real danger now is that there is little room for further efficiency gains; from 2015/16 this may well mean that service reductions will account for a higher proportion of required savings than efficiencies.

27. The impact of these funding pressures is being felt in several ways and poses additional challenges for the future. These impacts include:

- A squeeze on provider fees and associated concerns about provider viability and the quality, quantity and duration of commissioned care.
- Concerns that the squeeze on provider fees is leading to the homecare workforce not being paid the National Minimum Wage.
- A widening of the differential rates for services between those who self-fund their care and those who are council-funded. Under the Care Act this 'cross-subsidy' will become more transparent, which has the potential to further destabilise the provider market.
- A 25 per cent turnover in care staff and a 32 per cent turnover of nursing staff in nursing homes.
- Reconciling decreasing unit costs for residential, nursing and home care between 2010/11 and 2013/14 at a time when other major costs – particularly staffing and issues to do with the National Minimum Wage – have increased.

28. More broadly, an inadequately funded social care system will jeopardise vital services that support some of our most vulnerable residents; jeopardise decent quality; put further pressure on councils' overall budgets; jeopardise councils' ability to properly implement the necessary Care Act reforms; and undermine the sector's ability to support a sustainable NHS.

Policy shifts and legislative context

29. For five decades adult social care has been moving steadily away from the centralised planning and control that characterised the service in the 1960s. From the Seebohm Report in 1968, through to the community care reforms of the 1990s, and more recently with the work of Putting People First and the Think Local, Act Personal partnership, adult social care has been steadily taking a more person-centred approach.

30. Today the goal is to put the individual at the heart of service planning and delivery, joining up the different organisations and individuals within a community that each play a part in either providing services or contributing to an individual's wellbeing. There is a significant weight of continuity behind this evolution and notions of 'choice', 'control' and 'independence' are now firmly embedded as defining features of the system councils aim to deliver.

31. These dual developments towards personalisation and joined-up services render traditional perceptions of 'social care' obsolete. Adult social care is now seen much less as a 'welfare net' for those with the severest need or most limited means and has instead become a term that describes the various interactions and support that help people live their lives as they aspire to. This may be a set of complex interactions or support to help someone to stay independent at home. In turn this places a responsibility on providers and commissioners to broaden their perception of what a person, and communities, may need for everyday living.

32. As the approach to care and support has changed, there has been a concurrent shift in how the individual receiving services is viewed. Whereas a person may previously have described things being 'done to' them, the individual is now seen very much as a consumer with increased expectations about the services that should be on offer and the quality of those that are available. Direct Payments have given practical meaning to the principle of the individual being in control and Personal Assistants now account for 23 per cent of the community-based workforce.

33. Informal carers (with their own wellbeing closely linked to the quality of life of the person they are caring for) are also increasingly seen as consumers, experiencing and supporting access to a range of services.

34. This has further cemented the idea that achieving wellbeing is about making use of the whole range of local services, such as transport, housing (which is rightly assuming greater profile in current debates about the future of care), health, leisure and training, and education to name a few. It also emphasises the importance of the community and its role in ensuring a sense of universality across both services and consumers, who are neither advantaged nor disadvantaged by whether they are publicly of self-funded.

35. These important evolutionary shifts in emphasis and direction are now enshrined in one place through the Care Act. Section 1 of the legislation codifies the general duty of a local authority in respect of care and support as promoting an individual's wellbeing. This is drawn deliberately wide and includes consideration of personal dignity and both mental and physical wellbeing at one end of the scale through to the individual's contribution to society and participation in work, education, training or recreation at the other.

36. Reform of care and support services has been several years in the making and has drawn on a number of sources including the Dilnot Commission, which examined how care and support should be paid for; and the Law Commission, which reviewed the range of laws and statutes covering care and support. The Care Act reforms that go live from 1 April 2015 mean that all councils with social services responsibilities in England have to be consistent in their assessment and eligibility criteria, as well as offering deferred payment agreements to help prevent people from having to sell their home to pay for care.. The Act covers a number of areas including:

- general responsibilities of local authorities (wellbeing, prevention, integration, information and advice, provision of a diverse and quality provider market)
- the individual's journey through the system (assessment, national eligibility, charging, care planning, a cap on care costs)
- safeguarding adults at risk of abuse or neglect
- provider failure and market oversight
- transition to adult services
- carers' assessments and services.

37. A cap on the amount that people must contribute towards their care costs – one of the principle recommendations of the Dilnot Commission on paying for care – will come into place in April 2016. The aim of the cap is to remove people's exposure to the potentially 'catastrophic cost' of care, which strikes people arbitrarily depending on the care needs they may develop in later life. The proposals will require councils to keep track of people's progress towards the cap.

Governance and accountability

38. As social care has evolved, so too has the wider local government environment in which it sits. Particularly over the last 10 years, initiatives such as Local Strategic Partnerships and Local Area Agreements have opened up local public services and encouraged much closer inter- and intra-organisational working. Our world today is as much about local governance as it is about local government.

39. This is particularly the case in the arena of care and support. Adult social care services work with a range of local statutory and non-statutory partners, including other local government services, health, police, social housing, independent providers and the voluntary sector. Behind this sits an often complex pattern of family, neighbourhood and community support. These interactions demonstrate the importance and reach of local government's community leadership role.

40. Balancing local flexibility with inevitable calls for national consistency is central to the future of a successful system of care and support. Democratically elected local government must be able to decide with individuals what form this support should take, within a national framework that is adequately funded. In this context health and

wellbeing boards (HWBs) are emerging as important local focal points for planning how to best meet local population needs.

41. The Boards are relatively new and their development is variable across the country, reflecting differences in the history of local relationships and between the cultures of the NHS and local government. As debates continue about the potential role of HWBs in overseeing single local commissioning of health and care services it may be necessary to review their existing powers, duties, membership and capacity to ensure that each is ready and fit for purpose to take up the urgent task in hand.

42. Research commissioned by the LGA of four pilot HWB peer challenges shows that the boards have made a solid and enthusiastic start. They are now at a key stage of development and need to move forward to become a driver for change. This means building on the positives to date – such as strong local leadership and active engagement of CCGs – to progress further in areas such as better use of evidence and putting in place effective mechanisms to secure and drive delivery.

43. The Greater Manchester agreement is another important development and is a significant step in devolving control of social care and health spending to that area. We have long argued that truly integrating social care and health and taking decisions closer to where people live is crucial to improving services and keeping older people living in their homes for longer. We also welcome the commitment to focus on prevention of ill health and on closing the health inequalities gap.

44. We are keen for the government to support greater devolution of health and social care to other areas in England. While there is no single national template for devolution of commissioning, the experience in Greater Manchester will provide valuable lessons, from which all areas can benefit. We strongly support the subsidiarity principle, which ensures that decisions are made at the most appropriate local level.

Quality and improvement

45. Local government is committed to a sector-led approach to continuous improvement. In adult social care this is taken forward through the Towards Excellence in Adult Social Care (TEASC) programme that is led by local authorities, their partners, and regional ADASS. The ambition of TEASC is that excellent adult social care services will be delivered locally, supported by a regional and national programme of sector-led improvement, peer challenge and leadership support. The Programme Board for TEASC is chaired by ADASS and membership includes the LGA, Department of Health, CQC and the Think Local, Act Personal partnership.

46. The six priorities for TEASC for 2014/15 are:

- All authorities to publish local accounts. These are annual statements telling residents what their adult social care department is doing, how much it is spending, and how it plans to improve.
- Identifying and sharing best practice in regional systems
- Commitment to demonstrating outcomes
- Building confidence among stakeholders
- Ensuring an effective and transparent system for identifying and supporting authorities where there are concerns about delivery

- Clarifying the offer of support to organisations and over what issues

47. TEASC's recently published third annual 'Progress Report' shows that the adult social care sector has continued to improve despite operating in challenging times. There is a consistent picture of improvement nationally against the Adult Social Care Outcomes Framework indicators, which interact with the NHS and Public Health outcomes frameworks, and continued improvement in people's experience of receiving care and support. There is a particularly positive evidence of the role of personal budgets in giving people choice and control.

48. The need to maintain and improve the standard and quality of care raises fresh questions about the sustainability of a workforce where levels of pay, training, skills and status are not keeping pace with changing (and more complex) levels of need. This demands renewed attention to how services are led, commissioned and funded and what kind of job roles and career pathways should be designed to meet changing needs.

49. Overlaps between the health and social care workforce are clearly important in moving to more integrated working. The creation of cross-boundary roles will support integrated working but a number of challenges and barriers need to be addressed in order to maximise their potential. These include different terms and conditions, co-location, and difficulties in sharing information.

Adult social care: the offer

<u>Adult social care in an integrated system</u>

50. Alongside a developing focus on 'wellbeing' as described above, adult social care has also been shifting its emphasis from crisis response to universal prevention and recovery. Despite the financial pressures facing the service councils have spent 7 per cent of their adult social care budgets on prevention services for each of the last two years.

51. Starting with good information and advice services people are helped to identify the right support at the right time as their needs change. This is supported by local government's wider leadership role in developing resilient and supportive communities, for example through the planning and design of those communities, or working with employers to raise awareness of conditions such as dementia so that local populations are alert to the experiences and needs of individuals. Councils are also committed to working in communities to build capacity for informal care and support. It will be impossible to meet the challenges ahead without nurturing the potential of community-led and user-led services, including social enterprises.

52. The next level of prevention consists of services aimed at avoiding incidents or delaying the onset of conditions that can bring people into the formal care system with high level needs. Where such incidents do occur there are services that help people get back on track and regain their independence.

53. Similarly, where people do develop conditions that require long-term and complex support then the system offers services that are personalised, of good quality and

much better coordinated and joined-up around the needs of the individual. Personal budgets play an important role within this framework and the evidence is clear that people think they have helped to improve their experience of dignity in support and achieving their desired outcomes. Local government has a considerable track record in expanding the take up of personal budgets and the sector has made significant progress with the personalisation agenda. This is an area where the NHS could learn from social care and Integrated Personalised Commissioning (see below) provides an important opportunity in this respect.

54. This overall approach can be seen in different policy initiatives, many of which include work with health partners.

- Winter pressures: local councils have played a vital role in alleviating pressure on the NHS in the current winter pressures crisis. Specific work has included: increasing reablement support services; commissioning additional 'step-down' beds to help get people out of hospital; and establishing fully-integrated hospital-based discharge teams to help facilitate timely transfers.

- Better Care Fund: support with additional winter demand is immediate and reactive action to deal with current pressures. But councils and their health partners are also looking longer-term through the BCF. Despite local government's reservations and disappointment with the process this remains another important example of joining up services around the needs of individuals, improving outcomes, and helping to reduce demand on the NHS.

- Integrated Care Pioneers: the Pioneer areas are testing ways to make health and social care work together to provide better support at home and earlier treatment in the community to prevent people needing emergency hospital or residential care. The Pioneers are highlighting the fundamental importance of developing person-centred models of coordinated care built around a person's needs and through preventative action and stronger communities.

- Integrated Personalised Commissioning: local government is an active partner in this work to extend and develop personal budgets across health and social care. This further highlights the need for health and social care – and crucially the voluntary sector – to work together in designing effective approaches to supporting individuals with complex needs.

55. Adult social care's offer sits well with NHS England's Five Year Forward View and we agree that more decisive steps are needed to break down the barriers within the NHS and between the NHS and social care. But as the Five Year Forward View notes, England is too diverse for a one size fits all solution. We therefore welcome the opportunity to work with NHS colleagues in considering different options for care delivery models through the 'new models of care'. However, these will be no more effective than current organisational forms if care and support needs are not an integral feature of their design.

56. The benefits of adult social care's contribution to an integrated system accrue to both individuals and the NHS. For the former the service provides an increasingly personalised response that is geared towards delaying or avoiding the onset of more difficult and costly conditions. For the latter the service helps alleviate demand

pressures, allowing a focus on priority patients. The relationship is reciprocal, of course; NHS and clinical practice helps to delay the need for long-term care and support.

How can the NHS best work with adult social care?

57. A future system must play to these respective strengths; an NHS that is strong on diagnosis and emergency care, and a care system that is equally strong on personalisation and prevention. But if we are to realise the aspiration of an overall system that helps support a national population that is healthier, more independent, out of hospital, and pursuing their ambitions in their communities, then we must go further.

58. As a starting point, funding for both health and social care – not just health – must be protected. Social care is part of the solution for a sustainable NHS, not part of the problem, and so it needs to be protected in the same way that health is. A sustainable funding settlement (aligned with shared financial incentives on early intervention) should be underpinned by a simpler, unified outcomes framework that helps to ensure that each side of the system is working together to achieve shared goals and outcomes.

59. This has implications for what happens to the Better Care Fund beyond 2015/16. Local government is keen for this to continue but this must be on the basis of the fund's original intentions; local flexibility and no central prescription. To make a 'next steps' BCF properly accountable its pooled budgets should be singly commissioned through the local health and wellbeing board.

60. To meet the costs of moving to new community-based models of integrated care, which would include double-running costs, a transformation fund is needed. The size of this fund needs to be explored but with health and social care facing a combined funding gap of £12.3 billion by the end of the decade there should be scope to agree a shared position on what would make a meaningful difference.

61. More can also be done to embed a longer-term view of patients and users and their carers. Interactions with the people we serve should not be episodic and non-personalised; this only adds to the system becoming fragmented and siloed. Instead, health and social care needs to work closer together to truly personalise services in ways that fit neatly around the individual.

Discussion questions

62. We are keen to secure better and more consistent engagement between our respective organisations. How might this be achieved and how can we jointly better understand the evidence for the mutual dependency between health and social care?

63. If this better and more consistent engagement is achieved what should 'joint working' and/or 'co-production' look like in practice? And how might we collaborate in work to further understand the services or practices in adult social care that reduce or increase demand and cost within health, and vice versa.

64. Addressing the workforce needs of the future is central to a successful health and social care system. How can we best identify and resolve the joint workforce issues facing the overall system, particularly the impacts of funding reductions?

65. How can we fast-track joint health and care personal budgets for people who need them?

66. Would NHS England be interested in joint work on the sustainability of the nursing home market across the country given that the NHS meets the nursing costs of all residents and councils meet the costs of half of the residents? This could include ways of jointly determining future needs and the degree to which it is possible to care for more people at home.

67. The main vehicle for improving services in local government in recent years has been sector-led improvement. How might we work jointly to identify opportunities for developing sector-led methodologies in areas where we deliver jointly?

Conclusion

68. Both health and social care have a central role in supporting people with disabilities and long term conditions. The challenge for both services is to respond to the changing needs of the people of this country where an increasing focus will be on the growing number of people who need extensive health, care and support.

69. Of course there is an imperative to ensure that local services prevent or delay ill health and the need for services. At the same time the need to ensure coordinated, person centred and consistent care for those who need it will be central at a local level. The Five Year Forward View and the vision for social care set out in this report – along with sufficient funding backed by strong accountability and governance arrangements that are rooted in local communities – provide a basis for relevant health and care services of the future.

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