



Response to the Productivity Commission's  
Draft Report into Disability Care and Support

*The Young People In Nursing Homes National Alliance*

*May 2011*

The Young People In Nursing Homes National Alliance congratulates the Commissioners on their draft report into Disability Care and Support.

While the Alliance supports the general thrust of the report, we believe that scheme design elements as outlined in the draft report can be improved; and the links with existing community sector infrastructure can be harnessed to make the NIIS and the NDIS schemes more effective and viable.

The key element that the Alliance believes needs to be comprehensively reviewed is that of the Disability Service Organisations – a key part of the Alliance’s construction of these new schemes in its first submission. As the front end of the new schemes, these vital organisations need to do much more than just the role of financial intermediary that was ascribed to them in the draft report.

In the Alliance’s view, these organisations are key to the success of the new schemes because of their capacity to provide comprehensive and inclusive assessment and planning, manage service providers, ensure plans are being implemented appropriately, promote and involve local community and volunteers and, most importantly of all perhaps, proactively manage consumer and provider expectation around what the scheme can or cannot deliver.

### **Two schemes**

The Alliance congratulates the Commission on its recommendation of two schemes: one for the catastrophically injured and another for those with severe and profound disability. Establishing a separate scheme for the catastrophically injured will not only require our existing mix of fault and no fault injury schemes to be better aligned under an NIIS. Removing some of the most costly individuals to rehabilitate and support over the long term will enable an NDIS tailored to the long term care needs of those with differently acquired disabilities to be a viable reality. With each scheme having different realities and imperatives (such as income replacement and common law in the NIIS), these two schemes represent a more pragmatic option than one single mega scheme.

### **Numbers of individuals with severe and profound disability and consequent scheme viability**

The Alliance appreciates the difficulty of collecting adequate data to inform development of these schemes, the NDIS in particular. We are concerned that a lack of available and relevant data may suggest lower numbers of eligible people than has been identified in the Draft Report; and thus, a notionally lower cost of developing the schemes as a result. This is of particular concern regarding those with acquired disabilities. As previously able bodied individuals, these people (including those within the YPINH cohort) often do not identify as “disabled” in such population surveys as the Australian Census.

While we hope the development of an NDIS and an NIIS will significantly address this current lack, we also reiterate the need to trial interface engagements, the development

of service pathways and other coordinated trials to get a clearer idea of need (including unmet demand) and the costs this is likely to deliver to the schemes.

Because of the disability sector's poorly developed understanding of lifetime care and support, its view that more funding will solve all the current system's problems – a position increasingly supported by state governments desperate to solve their own systemic problems - and the enduring lack of appropriate and functional service infrastructure, regional or state-wide trials of the new scheme(s) prior to national implementation, run the very real risk that these will take place within the current dysfunctional disability mindset.

Trialling alternative approaches, particularly risk management approaches to assessment, planning and service delivery; service pathways and collaboration between service interfaces; as well as properly establishing the Disability Service Organisations, would not only alleviate these concerns and deliver important data; they would also ensure that these landmark schemes start from the best position possible.

#### **YPINH as priority group**

The Alliance is pleased that the YPINH™ group has been identified as a priority group for these new schemes and that early interventions will apply to these young people. Evidence is clear that early interventions offer the best approach to both recovery from catastrophic injuries and exacerbation of illness experienced by these young people; and to management of their long term care needs.

We believe the schemes proposed will deliver the certainty of response required to support the life time care needs of this group, as well as other Australians with disability.

We further believe, however, that the quantum of necessary funding the Commission has designated to deliver life time care and support for those with severe and profound disability, may be understated. Further work on service costs, transference of unpaid to paid care under the NDIS and the exact impact of the interface agreements with other programs will be needed before an accurate figure can be derived.

We understand the difficulty the Commission faces in estimating unmet need and any consequent cost estimates for NDIS service delivery especially. Both schemes will clearly need an extended 'shake down' period in which data can properly be gathered, the cost of needs evaluated, and service agreements (including schedules of costs) undertaken with providers of services, equipment and other resources negotiated and renegotiated.

That said, this work should be commissioned and actively pursued with State Governments and key community organisations as soon as the final report has been accepted by Government. The design choices that are made in determining the scope and operations of the Scheme are likely to have their own consequences. The better integrated the schemes are with the not-for-profit sector; the greater the resistance to

cost shifting that can be applied; the more that eligible individuals can access the full range of community supports available to all Australians, the lower the cost and overall risk to the schemes.

### **65 years as eligibility boundary**

The Alliance does not agree with the imposition of a 65 years age limit for access to services under an NDIS. While we understand concerns regarding cost blow outs due to ageing related support needs, too many of our members acquire their disabilities in later life.

Being diagnosed with MS or acquiring a brain injury at 66 is no different to being diagnosed with these impairments at 18 or 34 years of age. What will be different, though, is the available response if 65 years is retained as an eligibility boundary for the new scheme(s).

When 65 years was chosen as the definition of aged in 1907, average life expectancy was around 58 years. Today, average life expectancy is around 90 years and Australians are living longer and with better health as they do.

As the Younger People In Residential Aged Care initiative demonstrated, use of age as an eligibility mechanism that results in denial of vital services to individuals simply because they have aged beyond an arbitrary point, can have dire consequences. The end result under YPIRAC was often deterioration in health and, consequently, even greater imposts on the health, aged care and disability systems than would have been the case otherwise.

Our existing service system already delivers responses according to age, not need. To simply reiterate this system via an NIIS and an NDIS will be to miss an important reform opportunity that could see disability and aged care services aligned in a more complementary manner in the future.

One answer may be for the scheme to take account of equity as well as eligibility and provide partial eligibility for some services to applicants in this position. If, for example, an electric wheelchair is all that stands between a 67 year old returning home after exacerbation of an MS episode, the scheme could fund the wheelchair and leave aged care services to provide on going support.

### **Transition issues**

The draft report has rightly raised a number of issues regarding the transition to the new arrangements.

Given the fragmented state of disability services and the poor interface pathways that exist at present, there will need to be some high profile transition projects put in place to break up some of the current barriers and entrenched practices. There will be many areas that will need these kinds of 'leadership' or 'demonstration' projects to deliver the

workforce, the service efficiency and the planning and lifetime care management systems required.

Rather than simply trialling a cut down version of an NDIS in a region, it may be more useful to identify the transitional paths from the current system to the new one and choose a range of areas that need to be developed in order to make this possible. These projects can be started as soon as the key priorities are established, and would include:

- DSO organisational structures
- Lifetime Care and Support (case coordination and management) methodology
- NDIA claims management methodology
- Consumer involvement in care planning
- Cross sector planning (in education, health and aged care, for example)
- Workforce development
- Assessment methodologies vis a vis DSOs

One that is particularly relevant to the YPINH cohort is the joining up of health, aged care and disability services to ensure that the right mix of services from each service area is available in the right measure to people in this group.

One of the key reasons that young people are placed in aged care is that there is no spare capacity in the disability system, and that planning and recovery take more time than the system can accommodate. Even with additional funding availability in an NDIS, there will still be the need to access program areas outside the scheme (such as hospitals and aged care homes) as transitional arrangements.

It will be some time before a fully responsive market exists that can deliver these services directly to the scheme, so for this transitional period the Scheme will need to access programs and infrastructure that exists in separate program areas.

Regardless of whether YPINH are in aged care or at risk of entry to aged care, it may be that the scheme will need to fund aged care services to deliver some of the services required by these individuals. Given the large number of young people already in aged care, it is unrealistic to think that all of them will move to alternative services in the foreseeable future, so aged care will remain an essential part of the service response to the YPINH group well into this century.

The NDIA will need to embrace this reality and work with the aged care sector to expand its range of service offerings to younger people. A new revenue stream and policy imperatives could incentivise aged care providers to deliver much improved services to younger people. This is something that the NDIA will have to drive as an early scheme priority. It would also sit within current government thinking around expansion of aged care services to new areas of business and revenue streams.

Funding aged care transition programs will be a useful way of building capacity in the system, and enabling people to access step down services within the aged care system while alternative service options are explored.

Currently the Aged Care system provides transition care programs for older people enabling them to leave acute care settings while waiting to go to an appropriate residential care setting or recover to go home. Developing a range of pilots in transition (or interim care) for younger people with disabilities will be required as early as possible so that the facilities and expertise is in place for the scheme at large.

The Alliance would recommend that the Departments of Health and Ageing (DOHA) and Families, Housing, Community services and Indigenous Affairs (FAHCSIA) negotiate these pilots with disability and aged care providers in 2012 as a way of preparing the sector for the introduction of the NDIS, but also because it is sorely needed.

There are precious few of these interim care/rehabilitation facilities in Australia, and the ones that are there are largely blocked due to the lack of exit points to community services.

#### **Interfaces with other service areas**

The Commission's identification of crucial interfaces between the various arms of the service system including those between disability and health, are areas that obviously need to be managed carefully and proactively to ensure each service area delivers on its responsibilities.

We agree and would also make the point that proactive partnerships and collaborations between health and disability programs at the service level as well as the policy level are essential to develop and deliver the suite of services YPINH™ require. In other words, defensive management of these interfaces by any of the several protagonists involved, such as health, disability, aged care and housing, will only reinforce the existing deficient state of play.

Cross program interfaces cannot be allowed to be purely policy driven instruments that deliver the poor translation we currently see. The NDIA will need significant powers of persuasion and creativity to make these agreements work. The NDIA will not only need the mandate of Governments to make these interface agreements work, but will also need the support of sector organisations and consumer groups to make the agreements effective.

The new schemes must take a proactive stance to interface engagement. The NDIS, in particular, must seek to initiate change and encourage the development of innovative ways of engaging with other service arms so that the integrated service responses not only required by the YPINH™ group, but increasingly expected by any Australian with a disability, can be delivered. Such partnerships and collaborations will not also assist

during any transition period; they also have capacity to lower long term scheme costs by encouraging partnered contributions that will deliver benefits to all collaborators.

Managing these interfaces successfully and proactively is something the Alliance believes the Disability Support Organisations are best placed to undertake. The DSOs will confront the needs of clients for buy-in these other areas. They will also have to negotiate appropriate responses and will be well placed to promote systemic reforms of benefit to all service areas.

### **Employment and education services outside the schemes**

The Alliance does not support the inclusion of employment services and education services as part of an NDIS or NIIS funded program response. These service areas already exist and while they may not be as effective as they could be, replicating them or including them in an NDIS is not warranted. Instead, we need to make these community based programs responsible for what they should be doing, not offering them an easy out by inclusion in an NDIS or an NIIS.

Again, the Alliance believes that negotiating and partnering with these service areas, as with services in health, disability and aged care, are roles that Disability Support Organisations can successfully undertake. Doing so goes to the heart of expectation management amongst clients, providers and other service areas with their own legislative responsibilities to deliver.

### **Rehabilitation essential in the NDIS**

While rehabilitation is a clear benefit in the NIIS, the Draft Report does not identify rehabilitation as a benefit type in its description of the NDIS.

Therapy services are listed as a service type in an NDIS, but it is not clear whether rehabilitation (in particular slow stream rehabilitation) is going to be covered in the scheme. While this is something that an NIIS would deliver, it is also an integral part of the services an NDIS must deliver for individuals requiring habilitation or slow stream rehabilitation services to maintain life skills and/or slow disease progression.

The enduring lack of slow stream rehabilitation has been identified as a key cause of admission to aged care and increased disability in the YPINH group. This is especially the case for those with progressive neurological diseases as well as those young individuals acquiring hypoxic brain injuries from near drownings, stroke, hypoglycaemic coma in diabetes et al and who may not be eligible for an NIIS. Slow stream rehabilitation is currently a major service gap and is something that the NDIS must purchase for its clients as part of their ongoing recovery and support.

At present, the health sector provides limited fast stream rehabilitation to individuals able to demonstrate capacity to recover. It does so only in acute care hospital settings for short periods of time or specialist rehabilitation services in anticipation of discharge to full

function and return to community living. The health sector does not provide the important components of recovery that slow stream rehabilitation, in particular, can deliver.

Young people with progressive neurological diseases and those with acquired brain injuries not supported in the NIIS, cannot access the slow stream rehabilitation services they need via the health system. The NDIS must provide this essential component to not only promote recovery from acquired hypoxic brain injuries, but maintain the health and well being of its consumers over the long term.

In short, rehabilitation is required for recovery from

- hypoxic Acquired Brain Injuries that may not be covered by the NIIS including near drownings, strokes in young people, drug overdoses, asthma attacks et al
- exacerbations or episodes of progressive neurological disease like Multiple Sclerosis, Parkinson's and Huntington's diseases etc
- and to maintain health and well being over the long term for people with progressive neurological diseases

Rehabilitation is absolutely essential for the YPINH cohort and must be a funded service in both an NIIS and an NDIS. Not providing this in the NDIS may lead to increased applications to the NIIS for coverage (including litigation) by clients of the NDIS and the rehabilitation services the NIIS delivers.

### **Providers must be providers only**

The Alliance believes that providers must be providers of services only.

They cannot undertake additional roles such as advocacy, fund brokerage and assessment. Doing so will deliver a clear conflict of interest that ultimately disadvantages clients and puts scheme sustainability at risk.

### **Low to moderate levels of impairment**

As outlined in the Draft Report, individuals with severe and profound impairment will be covered under an NDIS. Those with catastrophic injury will be covered by an NIIS. While the Draft Report mentions Tiers 1 and 2 as part of an NDIS, these tiers are respectively largely concerned with provision of information including raising awareness in the broader community of disability and its impacts (tier 1); and referral to other service areas for response (tier 2).

The Alliance is concerned that the scheme as outlined in the Draft Report, does not address the needs of those with low to moderate support needs. These may include individuals who have made a significant recovery from, for example, an ABI but who still require some supervision to live their lives successfully and safely. If the scheme does not support these individuals in tier 3, and tier 2 is inappropriate or inadequate to their needs, where will their support come from?



Those with low to moderate levels of need could well be catered for by state government disability structures that have been relieved of the need to support those with high and complex needs.

### **Assessment**

The Alliance does not support an assessment ‘toolkit’ containing certain assessment ‘tools’ as the only assessment option. Instead, the Alliance strongly supports a proactive, risk management approach to assessment of need and planning of responses for all clients of the two schemes.

Such an approach relies on skilled (tertiary) assessors who gather information from a wide range of sources (including assessment ‘tools’ as needed), to build a clear picture of an individual’s current situation, current risks in play as well as any short, medium and longer term risks that may be ‘coming down the pipeline’.

Planning for these risks and putting responses in place to activate when the risk ‘arrives’, delivers better outcomes for scheme clients, can potentially reduce costs through proactive case coordination and program and sector collaborations; and enhance the scheme’s viability as clients become more aware of their potential and future needs and become involved in planning for them. This is especially the case for the YPINH group, many of whom never get the opportunity to think ahead and come to terms with the life they may lead in the future.

Information recovery from a wide range of sources should include input from family, friends and social networks; professionals in health, disability and allied health (including clinical assessments and other applied results), service providers, advocacy and information organisations, employers et al. “Assessment Tools” used in this process should include whatever is needed to deliver a comprehensive picture of the health and other risks the individual faces going forward

Once a clear and complete picture of the individual’s circumstances is in hand, planning to address issues/risks over the short, medium and long term can be undertaken and appropriate responses put in place.

### **Market forces as drivers of systemic reform**

The draft report’s apparent concentration on market forces to drive program and systemic reform as well as the development of appropriate service responses, is of clear concern to the Alliance and its members. The Alliance believes this expectation is misplaced.

As the Victorian Transport Accident Commission’s (TAC) example shows, reliance on market forces to drive system reform can be dangerous and counterproductive unless actively managed. The Alliance is aware of the fact that some private providers, who have

made TAC dependent on them over time, have stopped providing key clinical services to the TAC. Reasons include a 'lack of economic viability' for the provider; or that these individuals are just 'too hard' to support. As a result the TAC has had to develop a separate structure to buy and own its own high care accommodation in order to obtain what the market has failed to deliver. In some cases aged care accommodation is considered for TAC clients due to the lack of available options. This is not a consequence of a lack of money (as it is in the public system) but a lack of appropriate service development.

An over-reliance on market forces also risks the potential commodification of NDIS clients. One of the clear risks with a fully funded scheme is that the reliance on paid care or buying of services for all aspects of daily life will do just that and effectively commodify scheme clients.

As the UK's experience shows<sup>1</sup>, it takes more than market mechanisms to create a desirable and sustainable support environment. Making financial arrangements the key relationship between a service user and a service provider puts the end user at real risk of commodification under such an arrangement. Instead, schemes should encourage and make provision for families and friends to continue their involvement and provision of care to their loved ones as they are willing and able to do; and support community engagement (and support) as part of an individual's broader citizenship.

### **Life time care and reform**

In a similar vein, the report's acknowledgement of the need for reform in a number of areas but its lack of a declared framework to achieve this is also of concern. While such considerations may well be beyond the scope of the inquiry, they are fundamental to the successful introduction of both an NIIS as well as an NDIS.

To encourage discussion of what a life time care and support methodology might entail, the Alliance convened a national roundtable on this important topic at the start of April, earlier this year. Representatives from the disability, health and aged care sectors attended, as well as members of peak organisations, advocacy groups, providers, no fault motor vehicle scheme delegates and government representatives. The complete results of the roundtable are attached as an appendix to this submission. A briefing document that provided an overview of life time care and support schemes operating elsewhere was also provided to roundtable participants prior to the meeting. A copy of this briefing paper is also attached to this submission.

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<sup>1</sup> See

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_121508](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508). Accessed May 16 2011

In brief, the roundtable's outcomes included the following agreed observations

- An individual is not simply a single person but is an amalgam of family, friends, work colleagues, neighbours, clinicians et al. A Life Time Care and Support (LTCS) scheme, such as an NDIS, must enable input and contribution from all these support sources.
- Funding alone will not deliver much needed outcomes. As one example of this, the Younger People In Residential Aged Care (YPIRAC) initiative simply added additional funding to the disability system but did nothing to encourage or promote systemic reform. The "business as usual" response from disability services nationally did no more than develop more of the responses that had contributed to the birth of the YPINH™ issue in the first place. A LTCS scheme must include transparent and flexible engagement with those who directly and indirectly impact the individual's life including family, friends, employers, providers et al; as well as health, disability, allied health and clinical input.
- LTCS is inherently dynamic. Schemes must be flexible enough to respond to important life transitions between
  - Rehabilitation (in/out)
  - Work
  - School
  - Living arrangements
  - Palliation
- Formal and informal partnerships or collaborations are at the heart of developing and delivering the suite of responses a properly responsive LTCS scheme would manage. These can involve collaborations between health, disability, housing, aged care agencies, clinicians, family, colleagues, neighbours, providers et al
- In developing an NIIS or an NDIS, we will move from a system of need to one of certainty of response. Rather than *entitlement* to response, LTCS should be about the **rights of participants to responses because rights carry responsibilities**. This may help manage the transition from our current, crisis driven system to one where certainty of response exists; and also assist with management of client and provider expectation.
- It is critical to properly understand the individual's situation re: health, family, work, expectations, aspirations. In other words, there is more to adjusting to disability than just getting formal assessments and service plans right.
- **Strong support was expressed for the role of disability support organisations as detailed in the Alliance's submission, to be the 'front end' of any scheme and to**
  - establish eligibility
  - provide a suite of outcome based assessments and planning options
  - advocacy and expectation management services
  - some limited brokerage services to deliver timely responses immediately after assessment and planning is completed
  - scoping and engagement of suitable service providers

- delivery of peer support and other ‘informal’ services
- information and education including that concerning available options/choices
- proactively manage service interfaces between disability, health, aged care, housing et al
- deliver ongoing community based case coordination to get applicants underway; and to manage the dynamic nature of life needs over time
- involvement of volunteers and social networks
- Located within DSOs, case coordinators
  - undertake assessment across a range of areas and bring in relevant assessors (health, allied health, clinical, legal) as required. Assessors must be briefed according to the individual’s identified needs (e.g. maintain family unit, establish small business, making a will, deliver physical, rehabilitative, other supports). Other assessment needs to include how people can re-engage with their lives, communities, families, workplace (if relevant and desired)
  - broker and manage service provision and providers
  - manage client and provider expectation
  - liaise with and coordinate other service areas input and contribution including employment, education, health, aged care as needed
  - maintain a ‘watching brief’. That is, they are available and can activate as and when required, or at regular review intervals, but remain ‘dormant’ otherwise.
- DSOs and case coordinators manage the tension between what people may want or expect from the scheme; and what the scheme can reasonably deliver: i.e. inform/manage expectations while still ensuring that plans are in place to meet emerging needs.
- Strong support for a proactive, risk management model of case coordination to manage scheme members changing needs over the life course
- Declared view that the scheme should not internally manage case coordination/management, advocacy or dispute resolution. A number of the functions of the NDIA could well be decentralised to place the planning function within the Disability Service Organisation (DSO), close to the person and their community. The DSO would also be in a better position than the NDIA to work with the dynamic of formal/informal supports needed to deliver quality of life and outcome. This would also reduce the levels of disputation evident in comparable schemes where case management and funding decisions sit in the funding body. Internal case management was seen as a conflict of interest.
- DSOs were considered an essential filter between the commercial interests of providers and the objectives of the scheme. This filter can mediate what can be a one dimensional relationship that is driven by funding more than it is about delivering outcomes.
- DSOs should

- Be Not-For-Profit, block funded by government and contracted to the NDIA to perform all the listed functions
- Continue to offer their current mission driven offerings
- Form an effective coterie around the scheme, and share the difficult responsibilities of scheme viability and meeting client need. This is the key tension in the scheme, and the DSO model as defined by the Alliance in its first submission to the Inquiry, may provide a unique way of safeguarding the key roles currently performed by the NFP specialist organisations as well as the integrity of a new scheme.

It would also create a values based buffer between the commercial imperatives of providers and the scheme operation - a very important design imperative with a scheme of this scale.

The approach validated at the Alliance's National Life Time Care & Support Roundtable has also been recognised in the UK where the focus of 'social care' is on improving the lives of those with disability through building stronger local communities.<sup>2</sup> The UK Government's recently launched *Vision for adult social care: Capable communities and active citizens*, sets out how the Government wants to see services delivered for people; delivers a new direction for adult social care; and puts personalised services and outcomes 'centre stage'.<sup>3</sup>

The UK Government's vision for a modern system of social care is built on seven principles that the NDIA, NIIS and NDIS could easily adopt. These are:

- **Personalisation:** individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.
- **Partnership:** care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils - including wider support services, such as housing.
- **Plurality:** the variety of people's needs is matched by diverse service provision, with a broad market of high quality service providers.
- **Protection:** there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom.

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<sup>2</sup> See

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_121508](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508) and [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_121668.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121668.pdf) Accessed May 16 2011.

<sup>3</sup> See

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_121508](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508) Accessed May 16 2011

- ♦ **Productivity:** greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.
- ♦ **People:** we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. We need the whole workforce, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and the people who use services, to lead the changes set out here.<sup>4</sup>

As part of this new approach, the UK's sector wide statement of intent, known as "Think local act personal", embodies the sector's commitment to this collaborative approach.<sup>5</sup>

There is clearly much more analysis and decision making required before a viable scheme can be confidently designed and implemented. However, the Commission's work has taken a conceptual reform vision and given it practical form.

The final report will hopefully refine the design recommendations to deliver a viable and evidence driven case to Government.

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<sup>4</sup> Ibid.

<sup>5</sup> See

[http://www.thinklocalactpersonal.org.uk/library/Resources/Personalisation/TLAP/THINK\\_LOCAL\\_ACT\\_PERSONAL\\_5\\_4\\_11.pdf](http://www.thinklocalactpersonal.org.uk/library/Resources/Personalisation/TLAP/THINK_LOCAL_ACT_PERSONAL_5_4_11.pdf) Accessed May 16 2011

**Appendix A**

- a) Results of the National Roundtable on Life Time Care and Support
  
- b) Life time care and support discussion paper