Written evidence submitted by the Local Government Association (CSR0015)

1. About the Local Government Association (LGA)

1.1. The Local Government Association (LGA) is the national voice of local government. We work with councils to support, promote and improve local government.

1.2. We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

2. Summary

2.1. Adult social care is critical to the health and wellbeing of people with a range of often complex needs, their carers and families, and our communities more generally. Our aspiration is for better, more coordinated and more personalised care, enabling people to stay healthy, be supported to live in their community and to be in control of their care and their lives.

2.2. Achieving this requires a social care system that is responsive to people’s needs and seamless between different parts of the system. Care needs to be safe and of decent quality, protecting people from abuse and neglect. It also needs to be efficient, delivering better outcomes for every £1 spent.

2.3. The LGA has long campaigned for a fairer and more sustainable funding settlement for adult social care to help realise our aspirations. The November 2015 Spending Review (SR) and subsequent Provisional 2016/17 Local Government Finance Settlement (LGFS) provided an important opportunity to tackle the underfunding of adult social care and the many pressures facing the system.

2.4. Following the SR and LGFS local government faces an outlook in which total available funding for core services will be broadly similar in cash terms in 2019/20 to what it is today. The SR announcements of a council tax precept for social care and additional funding for social care through the Better Care Fund (BCF) are both seen as welcome recognition by the Government of the importance of care and support. These measures will go some way to addressing the funding gap facing social care.

2.5. However, there are still significant challenges ahead. In reality, a ‘cash flat’ settlement means that any pressures on spending (such as inflation, increased demand, costs of policy changes) will have to be funded by savings elsewhere. The LGA’s SR submission identified £10 billion of such pressures by 2019/20 many of which relate to social care budgets.

2.6. Savings required to deal with these pressures will inevitably impact on adult social care, which in turn will impact on the quantity and quality of
commissioned care. This will have knock-on effects to individuals and their families, other local government services, providers, the NHS and local communities.

2.7. Adult social care will also enter the 2015 SR period from unstable foundations. Over the course of the 2010 SR period the service had to close a funding gap of £5 billion, half of which came from savings and service reductions from within care and support. This had, and continues to have, serious implications for the provider market, the quality, quantity and duration of commissioned care, and the ability of the sector to help mitigate demand pressures on the NHS.

3. The distribution of funding for health and social care across the Spending Review period

3.1. The SR announced a 56 per cent cumulative real terms reduction in government grant funding for local government. When taking into account OBR forecasts of income raised locally by councils (council tax and business rates) the overall position is a 6.7 per cent real terms reduction in local government spending. This has translated into the provisional LGFS offer for future years, which set a reduction in core spending power (similar to local government spending above) of 0.5 per cent before inflation.

3.2. This contrasts sharply with funding for the NHS, which will receive £10 billion more in real terms by 2020/21 than in 2014/15. A majority of this will be frontloaded, with £6 billion available by the first year of the SR period. NHS spending will increase from £101 billion in 2015/16 to £120 billion by 2020/21.

3.3. In the 2010 SR period the Coalition Government made an additional £7.2 billion available for adult social care through a combination of additional funding in Formula Grant and the NHS transfer. However, the scale of the growing pressures and overall funding reductions to local government meant that adult social care was not immune to their impact. LGA analysis shows that councils therefore had to deal with a £5 billion funding gap in adult social care to meet their statutory duty to return balanced budgets (in contrast to the NHS which received real terms protection of its funding while NHS Trusts ran major deficits).

3.4. As with the 2010 SR the Government announced in 2015 that social care will benefit from additional funding, this time totalling £3.5 billion by 2019/20 and coming from two main sources. First, a new council tax precept for social care that will allow councils to raise council tax by up to 2 per cent each year. Second, additional funding for social care via the BCF rising to £1.5 billion by 2019/20. The precept is a cumulative increase each year and could lead to a rise in council tax of up to 17 per cent over the four year SR period, if councils also increase their ‘core’ council tax by 2 per cent each year.¹

3.5. However, given overall reductions to local government funding in the 2015 SR there is at least the possibility of a similar situation developing as was seen over the 2010 SR period. For example the full benefit of additional funding for social care (via the council tax precept and BCF) will be partially negated by the pressures on local government overall and the need for adult social care to contribute to councils’ global savings requirement.
3.6. In short, despite the well-entrenched and well-intentioned rhetoric of integration and a ‘single’ or ‘whole’ system of care, the two component parts of that system face dramatically different funding outlooks.

3.7. The provisional LGFS proposes distributional changes, including an equal percentage reduction in settlement core funding for different authorities of the same type. Different councils will have different views about this and the LGA intends to work with the Government to ensure it listens carefully to arguments put forward by councils during the provisional LGFS consultation.

3.8. This is important because there are still significant challenges ahead for councils. Savings will have to be made to compensate for additional cost pressures despite councils receiving a flat-cash settlement over the next four years. These pressures will include; those arising from general inflation, cost pressures in the care sector, increases in the number of adult and children needing support and rising levels of need, increases in demand for everyday services as the population grows, and increases in core costs such as national insurance, the National Living Wage, and pension contributions. Some areas will face higher levels of demand for some of the aforementioned services, particularly adult social care, while others, because of their geography, will have to address workforce capacity limitations (staff travel time and labour costs, for instance), pressures on providers, and the impact of higher levels of deprivation.

4. Achieving efficiency savings: their source, scale and impact

4.1. Adult social care has already made major efficiencies and the scope for more is now severely limited. The LGA’s estimate of the future funding gap for social care (set out in our Spending Review submission on care, health and wellbeing) included an assumption that councils will make 1 per cent efficiencies in each year of the SR period.

4.2. However, the term ‘efficiency’ is also subject to different interpretation across the sector. For example, the ADASS budget survey shows that some councils are classifying ‘reducing volumes of care packages’ as an efficiency. They estimated 28 per cent (£228 million) of the 2015/16 savings requirement is attributed to this route.

4.3. It is difficult to predict what level of efficiency may be achievable and the scope for further savings will inevitably vary from council to council. Such variation does not in itself suggest that significant scope for savings remain. Furthermore, detailed discussions on the scope for further efficiencies are difficult when many unfunded pressures remain within the system or are likely to be felt in the near future (see below).

5. Achieving service transformation set out in the Five Year Forward View at scale and pace through transformation funds

5.1. Financial pressures and the need for higher quality services make the working relationship between the NHS and local government more important than ever. For local government, working together to bring about real transformational change is essential, not just desirable.

5.2. For this reason the LGA has been a vocal supporter of the NHS Five Year
Forward View, particularly its strong focus on prevention. Achieving a shift from crisis response to prevention and early intervention requires an effective and adequately funded local government system. Without this, councils cannot maintain their vital contribution to the sustainability of the NHS.

5.3. This contribution can be seen in different ways. First, through adult social care and its role in helping to mitigate demand pressures (particularly seasonal pressures) on A&E. Second, through public health and the huge range of services that help stem the tide of disease and ill-health related to smoking, alcohol and obesity. And third, through councils’ wellbeing services that are preventative in the widest sense, such as housing, transport and leisure.

5.4. As set out below, all three of these contributions have diminished over the course of the 2010 SR and face further challenges in the 2015 SR period given the pressures facing the system.

Adult social care

5.5. The level of unmet need is rising and service reductions are beginning to account for a greater proportion of overall savings requirements. In many cases this simply postpones the point at which needs escalate, requiring more intensive (and costly) interventions from care and health.

5.6. Overall funding pressures have resulted in planned spend on adult social care prevention activity decreasing from £937 million in 2014/15 to £880 million in 2015/16, a 6 per cent reduction in cash terms.

5.7. Delayed transfers of care attributable to social care are increasing. The latest statistics (for November 2015) show that of the 153,200 total delayed days 62.1 per cent were attributable to the NHS, 31.1 per cent were attributable to social care (up from 26.7 per cent in November 2014), and 6.9 per cent were attributable to both the NHS and social care.

Public health

5.8. Local authorities were eager to take on public health duties in 2013 but many now feel they have been handed all of the responsibility without the necessary resources to do the job. The in-year cut of £200 million to the 2015/16 public health budget, and the further reduction of over £330 million over the SR period, undermine the shared objectives of improving the public’s health and keeping pressure off social care and health.

Wider wellbeing services

5.9. The LGA has argued for a separate transformation fund with the aim of implementing a new prevention strategy to drive real change. This would enable some double running of new investment in preventative services alongside ‘business as usual’ in the current system until savings be realised. The 2015 SR provided very little in this regard and is a missed opportunity to recalibrate the system towards prevention and transformation.
6. The effect of cuts to non-NHS England health budgets e.g public health, health education and Department of Health, and their impact on the Five Year Forward View

6.1. The LGA is concerned that reductions to the public health budget will be counter-productive to the essential prevention and early intervention services provided by councils and will lead to increased pressure on the NHS. Given that much of the local government public health budget pays for NHS services, including sexual health, drug and alcohol treatment and health checks, this will put increasing pressure on local services.

6.2. At a time when the Government has issued its firm commitment to the NHS Five Year Forward View, with prevention put very much at its heart, the recent announcement in the 2015 SR to make significant cuts to the public health budget over the next five years could undermine the objectives we all share to improve the public’s health and to keep pressure off the NHS and adult social care.

6.3. To put this in context, public health funding will be cut by 9.6 per cent in cash terms between 2016/17 and 2019/20, or just over £330 million. This is on top of the £200 million cut in-year in 2015/16. Local government needs sustainable resources to fulfil its new public health duties and be at the forefront of tackling the social and economic factors that contribute to poor health.

6.4. We urge the Department of Health to commission analysis to assess the impact these significant reductions will have, particularly on local authorities facing the greatest health inequalities and those communities with populations where some groups fare much worse than others (such as certain BME populations), those with high levels of deprivation, and those in rural and sparsely populated areas.

6.5. It is crucial that councils are given a free hand in how best to find the savings locally. With this flexibility, the task of finding the reductions more difficult. Councils are best placed to decide how reduced resources should be used to meet our public health ambitions locally.

7. Social care funding, including implication of quality and access to services, provider exit, funding mechanisms, increasing costs and the Care Act provisions

7.1. In its 2015 SR submission (joint with ADASS) the LGA set out the following key points:

- The 2010 SR provided additional funding for adult social care, which was intended to prevent a funding gap developing. However, it was insufficient to outweigh the reductions to overall local government funding and increases in demand, particularly those associated with learning disabilities.

- As a result, councils had to deal with a £5 billion funding gap in adult social care. They were successful in doing so but only by making savings and service reductions worth £2.5 billion within adult social care, and a further £2.5 billion worth of savings from other council services.
7.2. In its pre-Spending Review work, the LGA therefore called on the Government to:

- Close the funding gap facing adult social care, which was estimated as growing by at least £700 million a year before the cost of the National Living Wage is taken into account in full.

- Reinvest the earmarked funding for the delayed phase two Care Act reforms back into the care system, with the rest of the funding required to close the gap coming from reductions to spending on other government departments.

- Monitor and fund in full all additional financial burdens to adult social care including: Deprivation of Liberty Safeguards; implementation of the National Living Wage; seasonal pressures; and cost pressures facing providers.

- Create a £2 billion annual transformation fund to accelerate moves towards integration and prevention, with the expectation of 90 per cent return in investment by the end of the SR period.

- Expand the BCF with the NHS and local government contributing locally agreed proportionate shares of their budgets to the pool to improve health and wellbeing outcomes for their local area.

7.3. This estimate of the funding gap was a minimum figure and did not take account of significant system pressures, such as: the full cost of the National Living Wage; the cost of achieving compliance with the new Deprivation of Liberty Safeguards framework (£172 million per year); new burdens posed by the transfer of Independent Living Fund funding to local government; winter pressures; pressures on providers; and capacity pressures on the workforce.

8. Impact of the Spending Review

8.1. As above, the 2015 SR included two key announcements for adult social care. First, a new council tax precept for social care that will allow councils to raise council tax by up to 2 per cent each year; and second, additional funding for social care via the BCF rising to £1.5 billion by 2019/20.

8.2. The Government also announced that the funding earmarked for preparation for implementation of the Care Act 2014 will be included in the baseline for calculating Revenue Support Grant. The element is worth £307.7 million in 2016/17 rising to £513.9 million in 2019/20.

8.3. The continuation of adult social care funding for the Care Act reforms is welcome and adds much needed resources to take forward this important legislation. However, the inclusion of this funding in the baseline means that any costs arising now fall as pressures that will have to be offset by savings elsewhere.

The council tax precept

8.4. One of the immediate reactions to the announcement of the council tax precept for social care was that it would disadvantage those councils with higher levels of deprivation and weaker council tax bases. The
Government is therefore consulting on a distribution (and equalisation) mechanism that uses the additional funding for social care via the BCF to ensure that every council receives a proportionate share of the £3.5 billion funding overall based on 2013 adult social care relative needs formula. The Government’s proposed equalisation approach will see some councils receive none of the additional money for social care via the BCF.

8.5. The LGA does not typically comment on distributional matters. However, two points are worth making on this issue:

- The Government’s figures are based on an assumption that all councils will take up the precept flexibility, and take it up to the maximum amount (the full 2 per cent each year). At this stage it is impossible to say how many councils will use the flexibility and to what extent. This will be a political decision made locally.
- The Government’s figures for the council tax precept, and therefore the BCF allocations, also assume that the number of Band D dwellings eligible for full council tax will rise by 7.8 per cent, or 1.3 million, over the four year period. At council level, this varies from 0 per cent to 25 per cent and means that some councils might struggle to match this forecast.

Additional funding via the BCF

8.6. The additional money allocated to the BCF is not entirely new. Our understanding is that part of the ‘up to £1.5 billion by 2019/20’ will come from the announced planned £800 million savings from the New Homes Bonus (NHB) reforms. Questions therefore remain about what will happen to the ‘up to £1.5 billion’ if the level of NHB savings are not fully realised.

8.7. This funding does not commence until 2017, leaving real concerns about the situation in 2016/17. Furthermore, only £105 million will be made available in 2017/18. We are therefore concerned that councils will not see the benefit of this money until towards the end of decade when services supporting our elderly and vulnerable are at breaking point now.

8.8. The LGA is calling for the new funding of £700 million to be brought forward to help meet immediate pressures in 2016/17.

Future outlook

8.9. The scenario inferred from the points above means that adult social care enters the SR 2015 period from extremely unstable foundations. The impacts of this for the future are potentially manifold, and some are already apparent now.

8.10. Councils have a legal duty to balance their books but in the process services and the people who need them will be affected. Many councils have reached the point where efficiencies alone will not bridge the funding gap and they now have no option but to reduce services in the next round of budget setting.

8.11. The savings challenge does not include the effect of some serious structural weaknesses in the provision of care services. Without above inflation increases in fee levels the sector will see a growing shortage in
adequate supply in domiciliary care and further challenges in maintaining a well-trained and supported workforce that is able to deliver quality care. The situation in residential care is as demanding with many providers now at marginal viability and others only able to accept local authority prices by cross-subsiding from paying clients to council ones. Some providers may withdraw from the public sector market to concentrate on the self-funder market and the likelihood is that costs will have to rise more than planned if failure in supply is to be avoided.

8.12. Some efficiencies can still be made in some places by further reduction in direct provision, an increase in the numbers of direct payments, and increased use of technology and reablement strategies. But the savings that can be gained from such activity are limited. When all savings avenues have been exhausted we may see a variety of adaptive behaviours emerge, often without conscious design. These may include: longer waiting times for assessments; reductions in care packages, quality and safety; and an inability to properly fulfil Care Act duties, such as on prevention, support to carers, and information and advice.

Integration

8.13. The SR confirmed the continuation of the BCF, maintaining the NHS mandated contribution in real terms over the Parliament. It also confirmed the Government’s commitment to the integration of health and social care by 2020, with every part of the country required to develop a plan for this by 2017. This is helpful, as is the acknowledgement that it should be up to local areas to agree how best to integrate health and social care services locally.

8.14. However, we are disappointed that the level of ambition has not been increased for the NHS contribution to the BCF.

9. Process on achieving parity of esteem through funding for mental health services

9.1. It is important to note that councils, as well as the NHS, deliver mental health services. Most people who receive support from mental health services do so within the community and do not need hospitalisation. Councils deliver mental health services that range from person-specific and specialised, to public mental health improvement, to influencing the wider place-based determinants of good mental health and resilience. For example:

- Councils employ specialised ‘Approved Mental Health Practitioners’ (AMHPs), whose role it is to support and assess an individual with regards to the Mental Health Act.
- Community mental health teams (CMHTs) are community-based multidisciplinary teams that draw up and deliver a care plan.
- Councils provide specialised housing and social care provision for the ‘step down’ of an individual from an NHS mental health facility.
- Councils provide supported housing and care for those experiencing less severe mental health issues, and for their families.
Councils provide alcohol abuse and substance misuse services through their public health service provision.

Councils are responsible for the development of local Joint Strategic Needs Assessments, which should include local data on the prevalence of mental health conditions and associated services. This will feed into the priorities of the local Health and Wellbeing Board and local commissioning decisions.

Councils also have a safeguarding responsibility to those in society who may be more vulnerable to a mental health issue or crisis, including, for instance, looked-after children, those with learning disabilities and adults with dementia.

Councils either directly provide or jointly commission services for Children and Adolescent Mental Health Services (CAMHS).

9.2. There is a clear role for local government in achieving the national ambition to achieve parity of esteem for mental health alongside physical health. To this extent, any impact on council funding will also have an impact on funding for mental health services.

9.3. Whilst the NHS has received an additional £600 million investment in mental health services, there has been no similar recognition of the financial investment local government also makes in these services. To improve the support and care of those experiencing mental health difficulties, the whole health and care system needs to be adequately funded, which includes social care, housing, public health, as well as NHS health services. Targeting funding solutions and policy interventions at individual agencies in isolation will not deliver the improvements in care needed and is likely to increase the disparity in the ability of the whole system to provide support.

9.4. The mental health crisis concordat is an example of a successful cross-disciplinary response to better supporting those experiencing a crisis, and crucially, reducing the number of people who experience a police cell when they need a health intervention. Every council in the country now has a local mental health crisis concordat in place, based on a partnership between the local council, health sector, police and voluntary sector, alongside a local action plan.

21 January 2016

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1 The Government’s own figures on the benefit of the precept total £1.8 billion, not £2 billion, which in turn means that total additional funding by 2019/20, using the Government’s assumptions about take-up, CPI-related increases in ‘core’ council tax and the size of the chargeable council tax base is therefore more likely to be £3.3 billion.