Learning Disability (LD) Voices comprises charities, not-for-profit and independent sector companies that provide LD services in the UK, including Voyage Care, United Response, Lifeways, Wilf Ward Family Trust, Hft and Mencap. We represent 20% of the total sector provision.

LD Voices welcomes the opportunity to respond to the Health Select Committee’s inquiry into the impact of the Comprehensive Spending Review on health and social care.

Whilst we would like to be able to remunerate our staff more generously for the important work that they do, we are particularly vulnerable to the Government’s local government funding decisions and operate within an increasingly-difficult financial settlement. Without additional funding, the introduction of the National Living Wage (NLW) poses a real risk to the LD sector, and could result in services being withdrawn by providers because they are no longer financially viable.

Service closure will undermine the Government’s Transforming Care agenda, which makes transition of people with LD out of inpatient settings (and into the community) a priority. We would like to continue to play our part in the delivery of Transforming Care, but if the funding is not available to enable us to do it safely and effectively, the Government’s plans will fail.

CONTEXT: THE LEARNING DISABILITY SECTOR

The LD sector cares for 150,000 of the UK’s most vulnerable people. Our focus is on integrated and personalised care and support for people with a learning disability, acquired brain injury and autism.

Service provision delivered in accordance with Government policy

Our sector’s approach to the staffing and delivery of services is in line with Government policy; particularly the recommendations following the Winterbourne View Review of 2012. Today, LD services are delivered by tens of thousands of dedicated individuals in an array of small private settings throughout the country. The people we care for require life-long, complex support, often 24 hours a day, delivered by one or more carers. High staff-to-client ratio support in domestic environments is not only a regulatory and contractual obligation, but also the most appropriate and cost-effective way of supporting the UK’s most vulnerable people.

High frontline costs that we cannot reduce without cutting services

Given this service delivery model, ours is an industry for which frontline staff costs are a very high proportion of our fees: typically 70%, with the majority of employees paid at or near the minimum wage, because rates paid by commissioners for care make this the only viable option. Our sector nevertheless supports the NLW as a positive step for the lowest paid in society, and our people in particular.

The LD sector is particularly vulnerable to the Government’s local government funding decisions. People who are born with developmental disability, or who have suffered a major head injury, cannot make provision for themselves. Unlike the elderly care sector, there are almost no self-funders in LD services. As a result, local authorities (LAs) are the LD sector’s major customers, with the NHS playing a small role.

Conscious of the Government’s commitment to reduce the deficit, the LD sector has been focused on driving operational efficiencies and, over the past five years, we have cut costs and overheads to keep our fees static for LAs. There is no more scope to cut costs – our client base and requisite staffing model prevents us from being able to make frontline efficiency savings.

While other sectors faced with the NLW can reduce staff numbers, increase prices and obtain savings from their supply chain, the LD sector has none of these tools at its disposal. We are commissioned to provide hours of care so, when we are successful in increasing the independence of our clients, their care needs (and the care hours we are commissioned to provide) are reduced. This means that all of the financial benefits of improved outcomes flow directly to commissioners in reduced costs, and not to us.
There is nothing we can do to make frontline efficiency savings to ensure sustainability of our services unless we reduce the quality of the services we provide. This is not a viable or a moral choice for us, because the people who we support would suffer the potentially fatal consequences of reduced-quality care.

Given the combined impact of ongoing funding reductions from LAs and simultaneous wage increases driven by the introduction of the NLW, we have serious concerns about the viability of the quality services that we provide.

Case study: Martin Jones

Martin Jones* was born on 4th November 1988. His mother Hazel* was told the next day that he had Down’s Syndrome and, at nine, he was diagnosed with autism. Hazel said of that time:

“I was so tired, he slept three hours and was hyperactive and destructive for 21 hours a day and I was on my own. I was living a nightmare.”

After Martin attended residential school and college, Hazel had the opportunity to move him closer to home, into a possible placement for life. The first home worked well to start with, but after a year the ethos changed under a new manager. Hazel said:

“Horrible cost cutting measures were put into place. The relationship between me and the new management was non-existent. It became toxic and I feared for my son. I made complaints to CQC, Safeguarding and my MP. It was a very difficult chapter of our lives. Martin was very low, depressed, withdrawn and his behaviours increased again.”

After a long struggle, Hazel worked with Voyage Care to secure a new package for Martin. In October 2014, Martin moved into a new home. Hazel said Martin’s life “changed massively” from that day:

“...Every area of his life improved...Voyage listened to me - believed me - worked with me and the result is the environment, the staffing, the structure is right for Martin and he has become his own person as much as his disabilities allow him to be.

“Martin’s first decision on day one waking up in his own home was to have beans on toast - something that he loves and was restricted to once a week in the residential home he had left behind.

“Martin went from not having choices, visitors to his residential home not feeling welcome, to being a party thrower. He had a birthday/housewarming/Halloween party, a Christmas party, a New Year’s Eve Party - all within two months of moving in. He adapted and transitioned amazingly well into a life he was enjoying.”

Martin’s experiences show how much difference good care can make to the happiness, dignity and health of an individual with a learning disability.

*Names have been changed.

IMPACT OF THE CSR ON THE LD SECTOR: KEY ISSUES

1. The CSR significantly underestimates the cost of LD provision and social care generally

In the context outlined above, we are dismayed that the package put forward by the Government in the Comprehensive Spending Review (CSR) does not go far enough to resolve the current funding crisis that exists in social care provision; nor does it address the funding gap that the social care sector, and the LD sector in particular, is facing from 2016-2020.

The additional funds provided for social care by the CSR could amount to approximately £2.3bn in 2020 (£800mn from the optional 2% council tax levy plus 1.5bn from the Better Care Fund). The
King’s Fund has described the Government’s estimation of £2bn to be raised from the council tax levy as based on “completely implausible assumptions”, as it depends on all 152 councils in England applying the levy.\textsuperscript{vi}

To date, the Better Care Fund has been spent on the NHS, and none has reached any of the organisations represented by LD Voices. Assuming that this continues, the CSR provides only £800mn in additional funding for social care. This will represent additional funding for all forms of social care, not just LD.

Our most conservative calculations of additional LD provision needed in 2020 (from a 2015 base) is £1.166bn, subject to the introduction of the NLW (but with sleep-ins paid at flat rate – please see Annex). This represents significantly more than the proposed additional funding for social care. Today, LD absorbs 30% of social care funding, so if this persists, there will be a £926mn funding shortage for LD in 2020 (or £1.125bn if sleep-ins are paid at the NLW rate).\textsuperscript{vii}

![Funding Gap for LD Services in 2020](image)

The NLW will inflate the LD sector’s costs by 7.78% in 2016-17 and over 4% p.a. thereafter, with compounding effects (please see Annex). Without an increase, the essential surplus that we work to generate, which we deploy to invest in improvements and to meet growing need, will be entirely wiped out. This will result in a reduction in the development of new services and the withdrawal of existing services.

2. \textbf{2016/17 sees the highest cost impacts for the LD sector and the least amount of funding from the CSR}

Our analysis shows that an increase of over £380mn in funding from LAs is needed in order to sustain a viable LD sector over the next year alone (see Annex), yet there has been no indication from central Government or LAs on how this shortfall will be covered. In the context of this sizeable funding gap:

\begin{itemize}
  \item The local government four year funding settlement provides the lowest measure of locally raised funding for LAs in year one, compared to the subsequent three years
  \item The Better Care Fund additions provide nothing in 2016-17, and
  \item The LGA estimates that the LA 2% social care precept will raise, at most, £393mn in 2016/17 (for all social care services, not just LD), compared with £821mn in 2017/18 and £1.8bn by 2019-20 (although the King’s Fund estimates that the total amount raised will be unlikely to exceed £800mn).\textsuperscript{viii}
\end{itemize}

\textbf{2016/17 LD care budgets are being cut} compared to 2015/16 budgets, even at a time of well-reported rising need.\textsuperscript{ix}
3. **There will be a significant impact on the sector if ‘sleep-ins’ have to be paid at NLW rates**

In addition, there remains a serious question mark over the issue of sleep-ins. At present, 4% of our wage bill goes towards ‘sleep-in shifts’, when staff members sleep overnight at a service to provide emergency cover if necessary. Currently, this work is paid at a flat rate of £35-£40 a night, in accordance with the relevant primary legislation.

However, due to recent case law (not government policy), these sleep-in shifts could now be considered working time, and fall within the scope of the NLW. This will cost the LD sector approximately £139mn, and LD providers are not currently funded to pay this additional cost. The cumulative impact of this change would add over £800mn to our costs over five years (please see Annex).

4. **Without fee rises to sustain a viable LD market, services will close**

The CSR settlement implies that local government needs to squeeze an estimated 20% more value out of every social care pound by 2020 to meet its budget. As outlined above, there is simply no scope to cut the LD sector’s costs to achieve this objective.

In the context of 2016’s financial forecasts, following five years of flat fees, quality LD providers will withdraw services from LAs because they are financially unviable. This will result either in unnecessary and expensive re-tendering processes or an inability of the LA to provide such services. Either way, it will certainly result in poorer provision for highly vulnerable people. At worst, there is a very real risk of whole-system market failure occurring.

The NHS is the provider of last resort for the people who we support, many of whom have significant health needs. Supporting people in the community, as we have done for many years, also reduces pressure on acute healthcare services, whilst creating a better quality of life for our clients.

5. **Service closure will undermine the NHS’s Transforming Care agenda**

Post-Winterbourne View, the Government recognised that community provision is the best environment for people with LD, as well as the most cost-effective solution for the UK taxpayer. The NHS and local government have recently set out targets for the next three years to close 35-50% of in-patient provision for nearly 3,480 people, and build the right support for people to be discharged into the community. The Government’s Transforming Care agenda makes this transition out of inpatient settings and into the community a priority, but if the funding is not available to enable providers to do this effectively and safely, this agenda will fail, with devastating consequences for people with LD and their families.

**OUR REQUESTS**

The LD sector wants to play its part in the continued delivery of quality care for the people we serve, and we would like to transition the 3,480 people with LD currently in inpatient settings into our community facilities. Government action on two counts will help us fulfil this role:

- **Make additional funding available as a matter of urgency to help LAs to resource the vital care which vulnerable people rely on, sufficient to cover the 7.78% cost increases driven by the NLW in 2016-17 and 4% p.a. thereafter.**

- **Reduce the impact of NLW through ensuring that ‘sleep-ins’ remain paid at a flat rate.**

**CONCLUSIONS**

If suitable provision is not forthcoming, our clients – some of the most vulnerable people in the UK – will face service closure. For every one of those settings that closes, perhaps six or more individuals will have to be catered for by local health or social services, both coming at a much higher cost to the taxpayer and running contrary to the recommendations of the Winterbourne View Review.
We welcome the Health Select Committee’s focus on social care funding. There are, however, distinctive challenges facing the LD sector, which we believe warrants the attention of the Committee. We urge the Committee to consider a dedicated oral evidence session on LD, to ensure that the impact of the Spending Review on people with learning disabilities is fully explored.

We would be happy to provide further written or oral evidence to the Committee, and we look forward to working with you to ensure a future funding environment that sustains the right kind of care for vulnerable individuals.
ANNEX: LD VOICES COST CALCULATIONS

We have examined in detail the 70% of our budget that goes towards wages in the context of the introduction of the National Living Wage (NLW). The table below shows the planned increase in the year-by-year, rising to £9 an hour by 2020 (we have assumed an incremental increase year on year from its introduction in April 2016).

We have also examined the role of sleep-ins and the NLW. This change doubles the average cost of a shift from around £35-40 to £75-80.

<table>
<thead>
<tr>
<th>GOVERNMENT POLICY - NLW</th>
<th>LD SECTOR - NLW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>NLW Rate Increase Year on Year</td>
</tr>
<tr>
<td>NMW - Oct-14</td>
<td>£ 6.50</td>
</tr>
<tr>
<td>NMW - Oct-15</td>
<td>£ 6.70</td>
</tr>
<tr>
<td>NLW - Apr-16</td>
<td>£ 7.20</td>
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<td>NLW-Apr-17</td>
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<tr>
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<tr>
<td>NLW-Apr-19</td>
<td>£ 8.55</td>
</tr>
<tr>
<td>NLW-Apr-20</td>
<td>£ 9.00</td>
</tr>
</tbody>
</table>

To build our LD cost inflation scenarios, we have taken the total budget of the LD sector in 2014-15 coming from LAs and used the annual increase in sector costs figures outlined above. We have modelled two scenarios for the LD sector:

1. LD Sector costs with sleep-ins paid at NLW rates
2. LD Sector costs with sleep-ins paid at flat rates

The table below shows our resulting LD Sector budget scenarios for 2016-2020:

<table>
<thead>
<tr>
<th>(£, millions, p.a.)</th>
<th>Scenario 1 (Sleep-Ins NLW)</th>
<th>Scenario 2 (Sleep-Ins flat rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>£ 4,977.00</td>
<td>£ 4,977.00</td>
</tr>
<tr>
<td>2016</td>
<td>£ 5,364.25</td>
<td>£ 5,226.98</td>
</tr>
<tr>
<td>2017</td>
<td>£ 5,607.92</td>
<td>£ 5,455.35</td>
</tr>
<tr>
<td>2018</td>
<td>£ 5,852.05</td>
<td>£ 5,684.22</td>
</tr>
<tr>
<td>2019</td>
<td>£ 6,096.64</td>
<td>£ 5,913.58</td>
</tr>
<tr>
<td>2020</td>
<td>£ 6,341.72</td>
<td>£ 6,143.46</td>
</tr>
<tr>
<td>Total additional requirement 2016-2020</td>
<td>£ 4,377.58</td>
<td>£ 3,538.59</td>
</tr>
</tbody>
</table>

22 January 2016
REFERENCES


2 For example we have internalised 13% increase in Minimum Wage and absorbed auto-enrolment costs on pensions.


5 King’s Fund estimate given in this article: www.theguardian.com/politics/2015/dec/06/council-tax-offset-care-cuts-widen-gap-rich-and-poor-kings-fund?CMP=share_btn_tw


9 Learning disabilities are on the rise, with the estimated number of adults with learning disabilities projected to grow at compound annual rates of between 2% and 2.7% 2012–30. See: Professor Eric Emerson at the Centre for Disability Research (CedR), “The future need for social care services for adults with disabilities in England 2012–30”, NIHR School for Social Care Research (2013), Figure 2, p.4 (no page numbers given)

10 Mrs J Whittlestone v BJP Home Support Limited UKEAT/0128/13/BA and Esparon v Slavikovska UKEAT/0127/12/DA


12 For example: Valuing People (2001); Valuing People Now (2009); Transforming Care (2012)

13 Learning Disability Census Report - England, 30th of September 2015 (15 December 2015). Accessible: http://www.hscic.gov.uk/catalogue/PUB19428 This shares that previous estimates of people with LD in inpatient facilities of 2,595 (http://www.hscic.gov.uk/catalogue/PUB18793) should be augmented with the new findings of the census. Adding the unreported patients as identified by Assuring Transformation to the 2015 headcount puts the figure who were inpatients on census day 2015 closer to 3,480.