Pressures on health and social care

1.1 Pressures on social care budgets are real, systemic and are growing. In Essex, the number of people aged 75 and over will have grown by 25% in the decade to 2020 and the number of adults with learning disabilities will increase by over 18%. The pressure continues long term – over 65s are expected to grow by 52% in the period to 2031. The LGA have previously estimated a £1bn shortfall in funding by 2020.

1.2 These pressures are now also impacting on the care market. Research by Laing Buisson and the County Councils Network (which ECC contributed to) showed that there is a large and unsustainable differential between the price paid for care by private self-funders and rates paid by local authorities.

1.3 There is a risk that providers will leave the local authority funded market as authorities struggle to pay the going rate for care. In 2014, the National Audit Office found that some providers were struggling to meet all but “users’ basic needs and investing in staff skills and training”. Around half of local authority directors of adult social care reported that cost-saving was putting pressure on the financial sustainability of private sector providers.

1.4 While we welcome the national living wage, we nevertheless recognise that this will add further cost pressures on care providers. In Essex we estimate there will be an additional pressure of £21.3 million as a result of the introduction of the National Living Wage.

1.5 We are concerned that the measures in the Comprehensive Spending Review will not generate sufficient funding to maintain a functioning care market in the areas where there is the most need.

1.6 In Essex the challenges we face in commissioning social care are exacerbated by the fact that the Essex health system has received less than target funding levels for 10 years and the NHS now faces financial pressures of £280m by 2018/19.

1.7 In addition the local growth in emergency admissions to hospitals is higher than national average (8% vs 4% in 2014/15) and we have seen GP numbers decline in recent years as the population has grown. Essex has broadly 1,900 patients per GP (compared to about 1,700 per GP nationally).

1.8 These pressures and a lack of sufficient funding to tackle them place the Governments ambition for health and social care integration at risk. There is simply not enough money to both maintain provision and transform the system.
Measures in the CSR and Local Government Financial Settlement

Local Government Financial Settlement

2.1 We are concerned about the Local Government Financial Settlement and how it has been handled, which has hit well-run, low tax councils like Essex extremely hard. While we recognise that the Government needs to make difficult decisions to reduce the national deficit we are worried by the giant disconnect that is emerging between central government and local government on the ground.

2.2 The changes to the funding formula have been applied at the eleventh hour with little time for council leaders and cabinet members for finance to work through the implications to actual services and budgets. DCLG usually consult on planned changes to the way in which the grant will be allocated but despite early indications that there would be a consultation over the summer/autumn of 2015 this never happened.

2.3 The Local Government Financial Settlement leaves us needing to find £123 million in the next financial year alone. The challenge of having to balance our budget in 2016/17 is now a colossal one and one that will not be able to be achieved without making reductions to services.

2.4 The settlement also paid no attention to need. County councils (which typically have much higher proportions of their populations aged over 65) are receiving much greater reductions to baseline funding than other types of authority.

The Social Care Precept

2.5 It is important to recognise the 2% precept will not be anywhere near enough to meet the pressures on the social care system and should be seen in the context of the overall spend of local authorities on social care. In Essex we spend over £400m a year on adult social care. An increase of 2% on council tax bills would raise an additional £11 million a year locally but this would only account for 51% of the £21.3 million pressures we face as a result of the introduction of the National Living Wage (NLW), national insurance changes and other social care pressures in 2016/17. These are pressures that have largely been placed on us via national policy announcements.

2.6 In addition to concerns about the adequacy of funding generated by the precept we have concerns that the precept will have a disproportionate impact across the country. For example Research by the International Longevity Centre has used the government’s Live Tables on Local Government Finance with the ONS’ Mid-Year 2014 Population Estimates to demonstrate that areas with higher proportions of over 65s will raise less from the social care precept than those with low levels. Tendring in Essex will be one of the worst affected.

2.7 Although the precept will be propped up in these areas by the Better Care Fund, ILC estimate that even if the two proposals bring £3.5bn into adult social care, the proposals imply that the £3.5bn would be backloaded – with funding falling over the next two years before rising in the last. This means a continued short-term funding
squeeze for the sector as a whole and spending on care will only return to 2015 levels by the end of the parliament.

2.8 It is also worth noting that it was previously suggested the potential £6bn of savings from the delay to phase two of the Care Act would be used to support the existing system. We would support the call of the care sector in their recent letter to the Chancellor for clarity over what has happened to this additional money.

2.9 We also remain concerned that the future funding arrangements for social care remain unclear as the Care Act financial reforms were put on hold until 2020. We have previously called for an Independent Commission to hold a National Conversation about the future of health and social care and how it should be accessed and have noted that Norman Lamb MP and Simon Stevens is now making a similar call for a fundamental debate on the future funding of health and social care. This is essential if we are to ensure the future of our health and social care system. We have previously suggested that the Health Select Committee would be a good sponsor for such a cross-party review.

2.10 This inquiry could look at:

i. The opportunities to align the Health and Care systems. At the moment, one is free-at-the-point of use; the other is means-tested and there is confusion, duplication and unfairness. The Kings Fund report published in September 2014 identified several options to better align health and care funding.

ii. Opportunities to identify hypothecated funding streams.

iii. Opportunities to incentivise individuals to save for their own care and support costs. For example, ECC has previously mooted the idea of Care ISAs to give tax incentives (perhaps by local and national government) to save for the care costs of the future. We also note with interest the LGA’s recent suggestion of a £100 council tax rebate for carers.

iv. A refresh of Dilnot. If a cap is going to be introduced in 2020 it is important that the Government does not simply rehash the proposals from 2015 and hope that they are suitable for the conditions of 2020.

### The Better Care Fund

3.1 One of our biggest concerns is that the funding arrangements that have been announced will have a detrimental effect on integration. The Government has recognised the potential of integration and set out a clear aim for integrating health and social care services by 2020, supported by a strong funding settlement for social care. However this ambition faces significant risks.

3.2 Based on the Comprehensive Spending Review and subsequent announcements it appears that the Better Care Fund that was initially intended to support integration will be used to prop up areas struggling to generate income from council tax. This would shift its purpose from being transformative to maintaining current provision.
3.3 Local authorities and health services need both increased funding to meet ongoing demand and transformation funding to move to a more effective model of care in the future. Funding cannot be taken from one need to subsidise another.

3.4 Whatever its purpose the new Better Care Fund arrives a year to late. If it is going to be used to support areas with a shortfall, it is unclear how these areas will be supported in 2016. If integration is the ambition, why wait until 2017 when the financial situation of health and social care organisations will have worsened.

3.5 There is also limited information on how authorities can access the funding and what the criteria will be. Plans need to be submitted by 2017 yet no detail has been provided other than the plans must go must go beyond existing better care fund. Not only is this contradicted by suggestions it will go to areas struggling to generate sufficient income through council tax, it is unclear what happens to areas that are not in a position to move beyond the existing better care fund arrangements. It appears there is a possibility that areas could miss out on both increased funding through the precept and the Better Care Fund.

Business Rates

4.1 We welcome the principle of business rates retention and have long argued for it; however we are concerned that the government is proposing to link retention with councils taking on responsibility for other areas e.g public health, Attendance Allowance, and potentially police funding.

4.2 Our worry is that there is no link between growth in business rates and growth in demographic pressures. Some areas will see business rates income growing more slowly than demographic pressures. With an ageing population, Essex will likely be at risk of increasing divergence between our budget and need.

4.3 We accept that system will still require tariffs and top-ups, but this will need to reflect the responsibilities of the local authorities, their spending power, and levels of need. We await the detail and consultation but clearly it is important that this is done right. We would welcome Health Select Committee engagement in this process.

Public Health

5.1 Public Health again faces considerable cuts. In Essex we have had to cut £3.7m in 2015/16 and a further £2m next year. These are a substantial cuts in particular as the 2015/16 cuts were announced only in the summer.

5.2 We are disappointed that additional pressure has been placed on to Public Health when it has an important role to play in prevention. We are concerned that the short term savings this will generate could have a negative long term impact on health and social care needs and the prevention agenda across Essex and its health and wellbeing footprint.
5.3 These cuts also come at a time when nationally we are seeing more organisations interested in public health and examples across the country where public health have worked with organisations such as the fire service, police, district councils and local businesses to develop population based health models. Further progress could be at risk as a result of the cuts.

Mental Health

6.1 The extra £600m earmarked for mental health services in the Spending Review is welcome, but more needs to be done to achieve ‘parity’ with physical health. We note that this funding is focussed on improving access to talking therapies, and that the main focus of this investment to date has been on the treatment of depression and anxiety at primary care level.

6.2 It is also worth noting that the Centre for Mental Health have argued that during the last Parliament, funding for mental health services were cut, in real terms, by 8.25 per cent – almost £600 million. If this is the case then this increase merely resets the position rather than making progress towards parity.

6.3 We would like to see the same commitment that government has shown on talking therapies driving improvement in a wider range of services, including CAMHS, acute and crisis provision, early intervention and prevention and services in prisons and the criminal justice system. Other areas for investment would include training of staff such as psychiatrists and social workers, increased funding for mental health research, and improved integration with emergency services.

6.4 We also note the potential knock on effects of reductions in public health budgets and pressures on social care provision on services and on outcomes for people experiencing mental health problems. The impact of this on commitments to parity for mental health need to be further analysed.

6.5 We are aware that the independent Mental Health Task Force is due to publish its strategy for mental health at the time of submitting this evidence, and that this is expected to map out a strategy for care and support across all ages. The Task Force’s findings will inform the development of our approach in Essex – where we recently launched a new CAMHS service, and are currently developing a new strategic approach to adult mental health. The government will need to give careful consideration to its role to providing the investment to back the Task Force’s findings.

NHS

7.1 We are concerned by suggestions that while NHS England’s budget will rise by £7.6 billion in real terms over the period, other health spending will fall by more than £3 billion, a 20 per cent cut.

7.2 The King’s fund has also noted that this additional investment will be front-loaded, and much of this money will be absorbed by dealing with deficits among NHS providers and additional pension costs. They suggest that much smaller increases
in later years will see the NHS struggle to maintain services, let alone invest in new models of care and implement seven-day services.

7.3 If the NHS struggle to implement new models of care this will have a direct impact on demand for social care services and the sustainability of local authority funded social care.

Multi Year Settlements

8.1 In Essex we have worked closely with our CCGs to progress the integration agenda, but face challenges with NHS partners struggling to allocate resource. The suggestion that health services outside of NHS England will face £3bn of cuts means this situation is unlikely to get better.

8.2 One way in which it has been suggested local authorities could fund cost-saving reforms is through the use of reserves and the offer of a multi-year settlement was intended to support this.

8.3 Although the multi-year settlement will help many areas with planning and aligning budgets, the Government’s view on reserves is naïve and mistaken. Local government cannot run deficits so we need appropriate reserves to manage risk.

8.4 Carefully managed reserves are a key part of prudent financial management, and ensure that we are able to deal with unexpected events or costs. The vast majority of reserves are committed or held for schools. Other reserves are there as part of a prudent financial strategy.

8.5 We cannot therefore use these as a one off short-term solution to an ongoing problem of a chronically underfunded health and social care system.

Our Recommendations

9.1 Government – or possibly the cross-party Health Select Committee - initiate a national debate about funding of health and social care. With the delay to the Dilnot proposals until 2020 there is a risk that these will be outdated by the time they come into force, however there is also an opportunity to get consensus between central government, local government, health services and the public on the way forward. Government must start this process now to help provide certainty for the future.

3.1 The revised Better Care Fund must be brought forward and sufficient funding be allocated to integration and the development of new models of care.

3.2 The government to give careful consideration to its role to providing the investment to back the Mental Health Task Force’s findings and a commitment to funding a wider range of services and other areas for investment such as staff training and research.

22 January 2016