Written evidence submitted by County Councils Network (CSR0089)

Introduction

1. The County Councils Network (CCN) welcome the opportunity to submit evidence to this inquiry.

2. CCN represents 37 English local authorities that serve counties. CCN's membership includes both county and county unitary authorities who serve over 25m people (47% of the population). CCN is a member-led organisation which works on an inclusive and all party basis.

County Context

3. The impact of the Spending Review (SR) on health and social care in counties must take in to account financial and demand pressures, both existing and future. CCN member councils are subject to the most acute demand pressures of any local authority type. At the same time, counties have faced the largest reductions in funding and the quantum of funding available to tackle this demand is the lowest. These pressures are summarised below.

Demand

4. Independent research by LG Futures on behalf of CCN found that counties:

   - Have the fastest growing average annual rate of 65+ population of 2.0%, higher than all other local authority types and the national average (1.8%).
   - Experienced an 8.5% increase in the number of social care contacts from 2009/10-2013/14, against overall reductions in other authority types.[1]
   - Experienced a 52% increase in the number of referrals from primary and secondary health care sectors from 2009/10-2013/14.
   - Outside of London, counties saw the biggest increase in delayed days for patients awaiting residential placements (12.3%), nursing placements (3%) and home care packages (68%) from October 2014-September 2015.
   - Will experience a projected increase of 14.8% in the number of people with a limiting long term illness by 2020/21, higher than all other local authority types.

Finance

5. Past policy and funding decisions have led to counties not receiving the appropriate level of funding to meet the needs of a growing and ageing population. The decision to freeze the Social Care Relative Needs Formula (SCRNF) in 2013/14 means that counties no longer receive an annual uplift in their share of national funding based on demographic growth. As a result, per capita funding levels for counties will continue to fall relative to other local authority types.

6. In the current financial year county adult social care departments are facing an estimated funding shortfall of £959m. These estimates are based upon the predicted 'care home fee gap' for CCN member councils of £630m, coupled with Local Government Association (LGA) projections for our member councils on the funding gap in core budgets (£329m). This prior to the implementation of the National Living Wage (NLW) in 2016/17 which the LGA estimates will present an additional cost pressure across all local authorities of approximately 340m.[2]

7. The financial challenge facing counties means that:

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[1] The number of referrals made and subsequent contact with local authorities represent one of the principle quantitative measures of demand for social care services.

[2] National living wage to cost councils £1 billion a year by 2020/21, LGA, July 2015

- Counties have on average witnessed the largest reductions in adult social care funding (-22.9%) compared to other local authority types, and higher reductions in estimated cash funding (-20.1%) than the national average.
- Counties (£679) receive nearly one third less funding per head of population (65+) than the national average (£883) and significantly less than London (£1,182).
- Counties will be subject to £247m of unfunded cost pressures as a result of demographic growth, 52% of all demographic costs for English local authorities.

8. The use of overarching revenue Spending Power figures in the Local Government Finance Settlement (LGFS) and the percentage changes mask the quantum of funding available to different local authority types. In particular, higher than average council tax bases have not shielded CCN member councils from funding reductions, with cash and total funding remaining significantly higher in non-CCN areas and exceptionally high in London.

- **The distribution of funding for health and social care across the spending review period;**

9. CCN welcome Government's recognition in the provisional LGFS of the demand-led pressures being experienced in adult social care. However, the LGFS and SR do not deliver funding to the areas experiencing the most acute demand pressures.

10. During the SR period the NHS in England will be provided with £10bn per annum more funding in real terms by 2020-21 than in 2014-15, with £6bn frontloaded in 2015/16.

11. By comparison, upper-tier local authorities in England will receive a settlement that Government states will increase adult social care spending 'in real terms by the end of the Parliament'.[3] The structure of the settlement over the SR period means that funding for adult social care is effectively back-loaded. The expanded Better Care Fund (BCF) will only reach its full potential in 2019/20 and the effects of the optional social care precept will also only be fully realised in the same year.

12. The proposed distribution of funding could have far reaching consequences for CCN member councils. As shown above, counties already face a budget shortfall of approximately £959m for 2015/16 prior to the introduction of the NLW. This new burden, coupled with the highest levels of demand, fastest growing elderly population and falling budgets mean that additional funding is required immediately. Without significant funding being made available in 2016/17, counties will be in a position whereby the viability and continuing provision of discretionary services, and the safe provision of statutory services will come in to question at the detriment to some of the most vulnerable people in our communities.

13. Counties expected significant reductions in Revenue Support Grant (RSG) over the course of this SR period, as such planning for reductions in the region £670m during 2016/17. However, the detailed proposals set out in the LGFS consultation will lead to RSG being reduced by £854m (33.7%) followed by a 39.7% reduction in 2017/18 (See Table 1).

[3] The Provisional Local Government Finance Settlement 2016-17 and an offer to councils for future years: Consultation, DCLG, December 2015

Table 1 - Revenue Support Grant- Annual % Change

LA Type	16-17	17-18	18-19	19-20
CCN	**-33.7**	**-39.7**	**-41.9**	**-70**
London	-24.61	-26.4	-23.76	-31.96
Mets	-24	-25.2	-22.8	-29.8
Unitaries	-28.7	-31.8	-30.4	-44
England	-27.6	-30.7	-28.7	-40.1

14. These reductions in RSG are not matched by additional funding for adult social care, particularly in 2016/17 and 2017/18, leading to a significant funding gap and budget pressures for all counties.

Adult Social Care Precept

15. The SR documentation states that the precept will allow councils responsible for delivering adult social care to raise up to £2bn a year by 2019-20. These figures are based upon the assumption that upper-tier councils in England will utilise this additional power in full.

16. The option for councils to raise additional revenue through the precept was welcomed by CCN member councils. However, it is important to recognise that the use of this mechanism to raise income may not be politically possible for some councils. In particular, some administrations that were elected on manifesto pledges that stipulate that they will not to raise council tax in their local area over the course of their time in office.

17. The precept will also provide little to no funding for counties to address demand led pressures. In fact, if all CCN member councils were to impose the two per cent increase, this would only raise £200m in 2016/17. Much of which, if not all, will be offset by the implementation of the NLW.

18. As shown in Table 2, if fully applied by all upper-tier authorities the precept will raise the least per head in counties per head of 65yr+ population.

Table 2 –Social Care Precept Per Head of Population Allocations 65+ yr old population (£)

LA Type	2016/17	2017/18	2018/19	2019/20
CCN	37.34	76.28	117.16	160.06
Met	40.70	85.10	131.79	181.62
London	56.01	115.91	180.38	241.94
UA	41.2	84.67	130.8	179.8

19. In order to reduce the impact of the reductions in RSG over the SR period and also to acknowledge the potential consequences in the back-loading of the expanded BCF, ***CCN has proposed to Government that they should mandate that the optional 2% precept for social care is applied to both the district and county council tax levies in two-tier areas, with the district component passported to the county councils***. The current proposals effectively disadvantage two-tier areas, as unitary and metropolitan authorities are able to levy the 2% increase for social care on a larger council tax amount than county councils, where the charge is lower reflecting that districts deliver some services.

Better Care Fund

20. As stated above, the proposed methodology for distributing the expanded BCF and the delay in making funding available to local authorities will lead to significant budget shortfalls in the first two years of the settlement.

21. The use of the SCRNF to distribute BCF funding to local authorities ensured that those councils which were deemed to have a greater level of deprivation were remunerated in recognition of this. Research by LG Futures on behalf of CCN found that the difference in funding per head of population found that counties receive £90 below the national average and significantly less than areas such as Inner London (£632). [4]

Table 3:
Better Care Fund Allocations 2015-16

Comparator Group	BCF Funding (per head 65+)	Difference From CCN Allocation
County Council Network (CCN)	**£389**	**£0**
Inner London	£1,020	+£632
Outer London	£602	+£213
Metropolitan Boroughs	£570	+£181
Unitaries (Excl CCN Members)	£515	+£127
England	£478	+£90

22. The expanded BCF will provide £1.5bn funding by 2019/20 for local authorities to spend on adult social care. However, mirroring proposals on the distribution of RSG set in the LGFS consultation, the proposed formula to distribute this funding does not deliver against Government's stated aim of the settlement to address demand pressures where they are most acute. Table 4 shows that proportionally counties receive even less funding under the expanded BCF. Counties will receive approximately 50% less funding per head of 65+ population than Metropolitan Boroughs under the current distributive formula, under the LGFS proposals for the expanded BCF this will grow to 70% in 2017/18.

Table 4: Expanded Better Care Fund - £ Per Head Allocations 65+ yr old population

LA Type	2017/18	2018/19	2019/20
CCN	**3.30**	**49.46**	**94.05**
Met	25.59	145.07	246.42
London	21.26	134.71	224.57
UA	10.65	81.08	144.67
England	10.62	82	146.44

23. In essence, the proposed formula doubly disadvantages counties as it distributes funding using a methodology that also includes figures for the potential income from the optional social care precept.

24. In 2015/16 Government required local authorities and Clinical Commissioning Groups (CCGs) to plan to pool a minimum of £3.8bn for the BCF. Local partners went above and beyond this and agreed to pool £5.3bn. As part of the SR Government stated that it will '*maintain the NHS's mandated contribution in real terms over the Parliament*'. Although this assurance has been

[4] Social Care and Health: Funding & Cost Pressure Analysis, LG Futures, January 2016

welcomed by CCN member councils, the perilous state of NHS finances will increase the risk of the NHS withdrawing additional funding down to the mandated level of £3.8bn. Such moves will offset the additional £1.5bn identified by Government for adult social care made available through the expanded BCF.

25. The proposal to use the current SCRNF to distribute £183.6m of the Care Act implementation funding will also mean that the significantly higher growth in the older people's population in county areas is not recognised and counties are not remunerated appropriately for this pressure.

Additional Adult Social Care Funding

26. While we welcome the social care precept and expanded BCF to provide 'greater protection' to social care authorities going forward, these new funding streams combined favour other parts of the sector. The funding provided to non-CCN authority areas through the precept and BCF per head of population aged 65+ remains significantly higher during this Parliament. This disparity peaks in 2018/19, where London receives 170% per head, this disparity should be considered in the context of the demand-led social care pressures facing county areas. Taken as a whole, the redistribution of RSG, precept and BCF afford considerably less protection for CCN member councils as social care authorities and do not distribute funding according to need.

Table 5- Additional Funding Per Head of 65+ Yr Old Population Available from Total BCF/Social Care Precept Funding

LA Types	2017/18	% Diff CCN Allocation	2018/19	% Diff CCN Allocation	2019/20	% Above CCN Allocation
CCN	£79.58	-	116.62	-	254.11	-
Met	£110.69	39%	276.86	137%	428.04	68%
London	137.17	72%	315.09	170%	466.51	84%
UA	95.32	20%	211.88	82%	324.47	28%
England	93.67	18%	210.18	80%	322.56	27%

27. Taking these funding disparities into account and acknowledging that there is limited funding available for adult social care, CCN has proposed in its LGFS submission that:

'Government should revise the formula for 2017/18, undertaking a full needs-based review of funding over the next six months. This should adequately reflect the needs and demand pressures facing all councils. [5]

28. As shown above, the level and distribution of the funding provided over the course of the SR does not provide CCN member councils with adequate resources to address the introduction of the NLW, let alone the costs associated with biggest demand and demographic pressures of any local authority type. Without transitional measures to reduce the impact of RSG reductions in 2016/17 and 2017/18 counties will left in a position whereby the viability and continuing provision of discretionary services and the safe provision of statutory services will come in to question.

Achieving efficiency savings: their source, scale and impact;

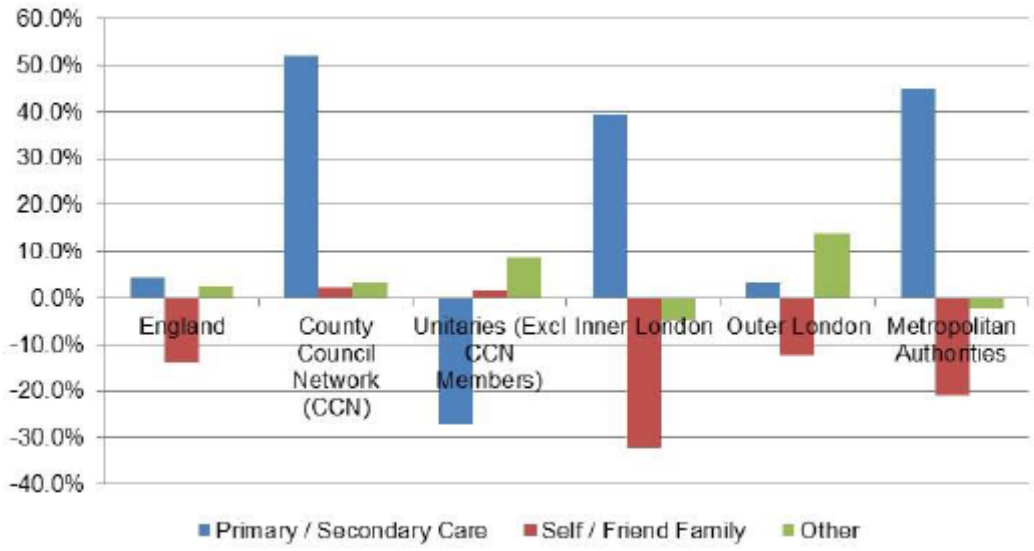
[5] Local Government Finance Submission, CCN, January 2016.

29. The dearth of funding available to adult social care across the SR period, in particular in 2016/17 and 2017/18, will require CCN member councils to make significant efficiency savings above and beyond those already achieved over the course of the last Parliament. It is also highly likely that the distribution and quantity of funding available to counties will lead to the withdrawal or a significant reduction to services.

30. It is important to recognise the interdependencies that exist between health and social care. In particular the impact that underfunding one part of the sector can have unintended consequences and in turn place increased financial strain on already stretched budgets, whilst also shunting demand from one part of the system to another.

31. One of the principle quantitative measures of the demand for social care services is the number of referrals made and subsequent contacts with local authorities. Research by LG Futures found that counties experienced a 52% increase in the number of referrals from primary and secondary health care sectors from 2009/10-2013/14 (See Figure 1). This uplift in referrals from primary and secondary care may indicate the additional pressures faced by CCN member authorities from measures to reduce delayed discharges, given the higher proportion of elderly population when compared to other local authority types.

Figure 1: % Change in Referral Type 2009/10-2013/14



32. The demand pressures being experienced across the health and social care system in counties led to a 37.1% rise in the number of delayed days attributable to adult social care for over 65s from October 2014-September 2015, significantly higher than Metropolitan Boroughs (11.4%).[6]

33. Counties (12.3%) have seen the biggest rise, outside of London, from October 2014-September 2015 in the number of delayed days, acute and non-acute, awaiting a residential placement. Using the indicative costs outlined in Table 6, it can be estimated that the total cost to these delays to the NHS of in counties alone is £27.5m, with the national cost estimated to be £55.3m.

[6] Social Care and Health: Funding & Cost Pressure Analysis, LG Futures, January 2016

Table 6: FCE based average costs 2012/13-2014/15[1]

Point of delivery	2012-13 £	2013-14 £	2014-15 £
Day case	693	698	721
Elective inpatient (excluding excess bed days)	3,366	3,375	3,573
Non-elective inpatient (excluding excess bed days)	1,489	1,542	1,565
Excess bed day	273	281[4]	303
Outpatient attendance	108	111	114
A&E attendance	114	124	132

34. Using the findings from the LaingBuisson report it is clear that **significant savings could be made by channelling NHS funding currently spent on delayed days in to providing additional capacity in the residential care market**.[7] The cost of delivering the equivalent number of days of care in residential placements using the 'care cost benchmark' would be £7.97m in county areas. Using the estimated average local authority fee rate that is currently paid to providers, the cost of delivering care through residential placements would be £6.6m.

35. Continued underfunding of social care and in-turn local care markets is also likely to impact on the ability of local authorities and the NHS to deliver efficiencies. Instability and polarisation is growing in local care markets, whereby providers increasingly focus on the more profitable self-funder market. This means that local authorities and the NHS will find it increasingly difficult to arrange care at market discounts, or worse, difficult to arrange care at all. This will lead to escalating costs to the health service and increasing delayed discharges, with councils and health providers being unable to find quality and affordable residential and nursing placements to reduce demand on acute healthcare.

- **The impact and management of deficits in the NHS and social care;**

36. The management of deficits is an uneven playing field when discussing health and social care. Local authorities are required by law to deliver a balanced budget year on year and as such are unable to run a deficit. By comparison, the NHS is in a position whereby it can and has reported substantial deficits since 2013/14 and Government has provided additional funding to offset these.

37. As stated above, the distribution and funding made available to counties over the course of the SR period will present significant challenges in 2016/17 and 2017/18. Such shortfalls in funding could potentially lead to counties having to reduce discretionary social care provision, much of which is preventative activity. In addition to this some social care services may have to be taken back to the statutory minimum in order for counties to be able to set a legal and balanced budget. Any reduction in social care services in a local area has the potential to increase demand on the NHS which will place further pressure on NHS budgets above and beyond that already being experienced.

- **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;**

38. The first argument presented within the Five Year Forward View centres on the fact that 'the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health'.

[7] County Care Markets: Market Sustainability & the Care Act, LaingBuisson/CCN, July 2015

39. Research by LG Futures found that CCN member councils receive significantly less funding per head of population for public health than other local authority types. Counties receive £37 per head, whereas London boroughs (£67), non-CCN unitary authorities (£57) and metropolitan boroughs (£66) all receive a higher per capita allocation.

40. At a time of finite public resources Government should consider whether direct NHS resources should purely focus on meeting demand i.e. those people, particularly the elderly, who are the main users of NHS services. At present NHS distributive formulae includes an element, SMR<75, that takes in to account health inequalities. It could be argued that a fully funded public health function would provide the most appropriate and core route for tackling health inequalities.

41. The announcement of an in-year reduction of £200m (6.8%) to public health budgets in 2015/16, followed by the announcement of average reductions of 3.9% over the SR period will be detrimental to delivering the efficiencies required as part of the Forward View. In addition to this, a reduction in public health funding is likely to impact on the type and level of preventative work undertaken by local authorities to reduce demand on adult social care and NHS services.

42. Government also announced in the SR that they will consult on options to fully fund local authorities' public health spending from their retained business rates receipts, as part of the move towards 100% business rate retention. Such a consultation would suggest that further reductions to local authority public health budgets are highly likely.

- **Social care funding, including implications for quality and access to services, provider exit, funding mechanisms, increasing costs and the Care Act provisions;**

43. As outlined above, the level of proposed reductions in the first two years of the SR has led to CCN member councils consulting residents about reductions to services such as buses. Such reductions are likely to have a detrimental impact on the access of vulnerable residents to core NHS services such as hospitals and GP surgeries.

Local Care Markets

44. Local care markets are of particular concern in the current and ongoing financial climate facing counties. The access of state-funded residents to quality care home placements is likely to diminish unless there is a significant uplift in funding for providers to place them on a sustainable financial footing.

45. LaingBuisson's research found that due to funding reductions over the course of the last Parliament, counties have rightly exercised their strong market position as a 'bulk' buyer of social care placements to secure discounted rates from care market providers' over time.[8]

46. This has led to a widening gap between local authority residential and nursing care home fees and providers' costs. However, to a significant extent, it has only been possible for councils to continue to secure discounted care fees because providers have been able to charge self-funding residents fees in excess of the cost of care, to compensate for this shortfall in council fees.

47. If local authorities are unable to pay a higher fees than they currently do to stabilise local care markets, then care home providers will have to consider how best to ensure their business stays financially viable. This is likely to mean many providers will seek to secure business from a higher proportion of self-funding residents, with new investment concentrated in this segment of the market to maintain or increase profitability.

[8] County Care Markets: Market Sustainability & the Care Act, LaingBuisson/CCN, July 2015

48. This care market provision will not typically be accessible to CCN member councils and the NHS for residential, nursing or continuing health care placements, as providers will concentrate on higher specification support, with high fees, beyond what councils and the NHS can afford to pay. This will result in local authorities and the NHS finding it increasingly difficult to access suitable and affordable care arrangements for the increasing numbers of state supported clients.

49. Continued underfunding of adult social care could potentially lead to a **two-tier care market developing, with a differentiation in quality of care between self-funders and state-funded clients giving rise to substantial risks to the safeguarding of clients.** In addition to this the quality of care home provision may also be impacted upon by the reduction in funding for the Care Quality Commission of 25% over the course of the SR period.

50. At a time when Government is focusing on improved health and social care integration and driving down costs, allowing instability and polarisation in care markets to worsen would be highly counterproductive. Local authorities and the NHS will find it increasingly difficult to arrange care at market discounts, or worse, difficult to arrange care at all. This will **lead to escalating costs to the health service and increasing delayed discharges, with councils and health providers being unable to find quality and affordable residential and nursing placements to reduce demand on acute healthcare.**

- **Impact of the spending review on the integration of health and social care**

51. The SR set Government's ambition for all local areas to develop and agree health and social care integration plans by 2017, to be implemented by 2020. This is an ambitious timescale and must be followed by early clarity on the criteria and process for agreeing integration plans.

52. However, as set out above, the distribution of the provisional LGFS over the SR period will mean that CCN member councils will be faced with significant budget shortfalls above and beyond what they had predicted. This is due to the redistribution and reduction of RSG over the SR period, coupled with the full effect of the expanded BCF and optional social care precept not coming in to full effect until 2019/20. By comparison the NHS will receive a settlement worth £10 billion per annum more funding in real terms by 2020-21 than in 2014-15, with £6 billion a year frontloaded in 2015/16.

53. The distribution of the provisional LGFS means, particularly in 2016/17 and 2017/18, that counties will be faced with difficult decisions about the viability and continuation of discretionary services. Significant reductions RSG will also bring in to question the safe provision of statutory services. At the same time, there may be little incentive for the NHS to integrate with social care in county areas due to the precarious nature of council budgets as a result of the provisional LGFS.

54. The differences in how funding is distributed for the NHS and social care over the SR period are not conducive to delivering integrated frontline services in the timescales set out above. **To deliver the £22bn efficiencies required as part of the Five Year Forward View and to deliver a sustainable adult social care system, Government must treat health and social care as a single system**. In essence if one part of the system receives a frontloaded funding settlement, so should the other part. Without sufficient investment in social care, then it is unlikely that the NHS will achieve its efficiency targets and will continue to deliver year on year deficits.

55. LG Futures research found that **there is significantly less funding available for NHS and social care investment in county areas**.[9] Using funding estimates for both older people's

[9] Social Care and Health: Funding & Cost Pressure Analysis, LG Futures, January 2016

adult social care and health funding, they estimate that counties are funded at £78 per head below the England average and are the lowest funded area, this equates to approximately £1.98bn less funding than the national average. This dearth of funding will be compounded by the funding and distribution decision made as part of the provisional LGFS. In turn, this will mean that the total quantum of funding available in county areas to invest in integration will be lower than in other local authority types.

56. One of the key levers for integration established by Government was the BCF. This was created to provide a '*local single pooled budget to incentivise the NHS and local Government to work more closely together around people, placing their wellbeing as the focus of health and care services*'.[10] As shown previously, counties receive and will continue to receive significantly less funding per head of 65+ population as a result of the current and proposed funding formulae. This is only compounded by Government's decision to freeze the SCRNF in 2013/14 means that counties no longer receive an annual uplift in their share of national funding based on demographic growth. As a result, per capita funding levels for the CCN authorities will continue to fall relative to other local authority types.

57. Health and Wellbeing Boards (HWBs) were also established, in part, to encourage integrated working between health and social care partners. Although they were empowered by Government to oversee the BCF, these boards were not provided with a new and strengthened governance framework. HWBs play a crucial role in bringing together a range of health and social care partners around a table, but in some cases have become a talking shop. They do not commission services, they cannot hold a budget and they have no delegated powers to require local partners to participate in the integration process.[11] **As part of the integration process Government should consider how to strengthen HWBs to facilitate them being the leading body to drive integration at a local level.**

58. CCN have long-argued for the need to shift services towards prevention and early intervention.[12] To reduce the long-term cost of caring for an ageing population on local government and the health service, preventative services need to support people to remain out of the adult social care system for as long as possible.

59. Integration and devolution alone will not solve the underlying funding problem that currently exists in social care. Improving and aligning incentives will play a key part in bringing partners together in local areas to improve outcomes for residents, deliver integrated services and in-turn efficiency savings. To achieve these goals **incentives must move away from rewarding contacts with service users and reward the NHS and social care for improving outcomes and preventing people from entering expensive crisis care unnecessarily**.

27 January 2016

[10] *Better Care Fund Planning, NHS England*
[11] The State of Care in Counties, The Integration Imperative, County APPG, 2015
[12] Delivering the Better Care Fund in Counties, CCN, May 2014