Local Government Association

Adult social care spending round submission

April 2013

1. Summary of key proposals

The long-term pressures facing adult social care are well understood. Budgets have reduced, demography is creating pressure and options to offset shortfalls in resources are becoming increasingly limited. Plans for major reform of care and support and welfare will add further pressures and costs. There are a number of issues to consider:

The care and support reforms must be fully costed and their wider implications acknowledged and funded, particularly given the likely costs councils will face in 2015/16 ahead of implementation in 2016.
NHS – local government is the most efficient part of the public sector and getting adult social care right alleviates pressure on the NHS. It is therefore illogical to protect NHS budgets and logical, and in the interests of integration, to increase resource transfers from the NHS to support social care to enable pressures to be managed locally.
Efficiency - further work must be done to understand how to draw out efficiencies across the health and social care system. The scope for further efficiencies within social care is limited, so we must now look across the whole system.
Integration - is now economically and socially essential and must be led locally by Health and Wellbeing Boards. More must be done to help local areas unlock savings which can result from better integration across the health and care system. The community budget pilots have demonstrated that significant steps towards integrating health and care and refocusing expenditure on prevention are possible and can make large savings.

Addressing the above and delivering a good settlement for adult social care is not about ensuring 'business as usual'. Rather it is about ensuring a firm foundation from which the Government's wider care and support reform agenda can be taken forward.

2. Context

Adult social care is facing a number of pressures across all client groups.

- Additional funding for social care was allocated in the 2010 Spending Review but its impact would only be felt if we were in a settled state. Significant cuts to local authority funding has inevitably meant that adult social care has had to contribute to savings – particularly as the service represents more than one third of councils' budgets, which is the biggest area of discretionary spend for councils. Despite protecting the service as much as possible councils have had to reduce their adult social care budgets by £2.68 billion, 20 per cent of the budget, over the last three years. Although there is no exact science to capturing what is genuine efficiency and what is not, evidence from the ADASS Budget Survey indicates that this figure is made up of efficiency (75 per cent); service reductions (18 per cent); and income and charges (7 per cent). Continuing to make this level of saving annually is simply not sustainable.
- For 2013/14 adult services directors are looking at a number of medium/high priority areas for making savings. 95 per cent have identified better procurement as such an

area, and 81 per cent are looking to shift activity to cheaper settings. However, while this may produce savings in the future the scope is likely to be limited. 67 per cent of directors are aiming to expand independent sector provision, but this is a saving that can only be made once. 61per cent of adult services directors believe stopping unnecessary services is a medium/high priority area for making savings and 60 per cent are looking to reduce the number of people in receipt of care. Such moves will clearly impact on the availability of services and the continuity of the care setting.

- The majority of adult services directors believe that controlling wages or increasing user contributions are low priority areas for savings. In the case of the former this is because most people working in adult social care work for external providers. In the case of the latter this is because there is very limited scope to increase charges beyond what local authorities have done already.
- Councils are facing a demographic pressure of three per cent of adult social care budgets. It costs over £400 million a year to continue to provide the same level of service, which excludes the impact of inflation. This cost must be considered in the context of, for example, the £1 billion spent each year on concessionary fares and the estimated £2 billion spent each year on winter fuel payments. At a time of such significant pressure on public spending we need an open debate about where resources are best allocated to support those with the greatest needs.
- The greatest demographic pressure comes from adults with a learning disability (44 per cent of total demography pressure), followed by older people (40 per cent).
- 30 per cent of respondents to the ADASS 2013 Budget Survey report that fewer people are currently able to access social care, while this grows to 50 per cent of respondents predicting poorer access in two years' time. However, while fewer people are accessing services, the cost of care packages for those who are is increasing.
- 28 per cent report that savings are currently putting more pressure on health and 36 per cent predict this pressure will grow in two years' time. 48 per cent report that their providers, who are largely SMEs, are currently under financial pressure, while 57 per cent predict providers will experience financial pressure in two years' time. And 39 per cent currently report an increased level of legal challenge, while 43 per cent expect this level to increase in two years' time.
- Research into unmet need by Southampton University identified that only 20 per cent of people who report difficulties with dressing and bathing receive support from social services. 50 per cent are supported by their family and friends.[1] However, in his work on funding reform Andrew Dilnot suggested that the willingness and ability of family carers to perform a caring role is reducing.
- Eligibility thresholds cannot be raised much higher, 87 per cent of councils are now at the substantial/critical threshold.

[1] http://www.ons.gov.uk/ons/rel/population-trends-rd/population-trends/no--145--autumn-2011/ard-pt145-unmet-social-care-need.pdf

- Income from residential care charges is projected to fall. The scope to offset budget reductions via income is therefore decreasing.
- Pressures faced by providers, such as food and utility costs and increases in the National Minimum Wage, are proving very challenging. Further changes to SERPS in 2016 will also be significant. Councils are working closely with providers but supporting them through fee increases is becoming harder. The average increase is 1.5 per cent, which is below the rate of inflation. This is set against national policy pressures to ensure market stability and quality as part of improving outcomes for individuals.
- The Government's far-reaching welfare reforms are likely to increase demand for care and support services and impact further on the ability to raise income. And the care and support reforms, including the capped-cost model of funding reform and Care and Support Bill, will entail substantial *additional* costs for the sector.
- Additional duties and responsibilities, such as the transfer of responsibility for social work in prisons, changes to death certification and the closure of the Independent Living Fund, will all impact on budgets. Government must quantify these burdens for inclusion in the 2015/16 settlement and beyond.

3. Funding for care and support reform

We welcome the Government's commitment to take forward funding reform as recommended by the Dilnot Commission. **However, the decision to bring implementation forward to 2016 will expose councils to increased start-up costs during 2015/16.** In particular, additional costs will arise from:

- Increasing numbers of individuals, particularly self-funders, presenting themselves for an assessment so that their care costs from April 2016 count against the cap. This will carry a cost in itself and has significant implications for the workforce in terms of capacity and skills.
- One-off costs to support ICT changes and data sharing that will be required to get the system up and running.
- The process of assessment to identify individuals with lower level needs that councils could support through universal services that are not subject to eligibility criteria, such as telecare and reablement.

We welcome the Government's inclusive approach to implementing these reforms and will participate fully. However, this spending round must recognise that the cost estimates for funding reform will not be sufficient given the accelerated agenda. There will be an earlier cost to councils because implementation has been brought forward, but there will also be an additional cost because, initially, councils will have to deal with the current backlog of self-funders who will need to be assessed. **It is essential that the Dilnot Implementation Group fully tests the assumptions about new burdens built into the financial allocations given the earlier timetable.**

We estimate that a one-off figure of £500 million is needed to see the reform process

through. This comprises £200 million which Dilnot said would be the annual cost of assessment, an additional £200 million to deal with the backlog of people coming forward, plus £100 million for systems changes. It is essential that government works out the cost of its funding reforms accurately and fully funds them.

4. Continuation of the NHS transfer to Adult Social Care

The additional money for social care from the NHS, announced in 2010, has helped mitigate the impact of the overall reductions to council funding. It has also helped to fund demographic pressures and some new services, particularly integrated prevention activity. For 2013/14, 32 per cent of the NHS transfer money has been allocated to avoid cuts, 14 per cent to cover demographic pressures and 18 per cent for investment in new services. 36 per cent is yet to be allocated.

This approach must be extended for 2015/16. Without it the ability of councils to run effective adult social care services will be at risk and overall costs to the NHS will rise. It also runs the risk of derailing NHS efficiency targets given that getting adult social care right can alleviate pressures on the NHS. For example, higher cost social care at the end of life tends to mean lower costs to health; reductions in social care may therefore increase demand for health services.

Local government has proved itself to be the most efficient part of the public sector and it is counterproductive to protect health spending and penalise adult social care. From 2013 the NHS resources for social care will be transferred to councils via NHS England. Clinical commissioning groups and local authorities must be able to continue working together to agree the allocation of the resource. **Funding from the NHS to social care should not be ring-fenced and the NHS Outcomes Framework must recognise genuine health outcomes which can be linked flexibly to activity. Allocations should be made transparent and there must be scope to spend the money on locally determined care, health and wellbeing priorities, as determined by the Health and Wellbeing Board, which should hold the allocation until integration plans are agreed. This means resource would be allocated in a way which makes most sense locally and promotes integration and innovation.**

5. The scope for further efficiencies

We need to recognise that there are now very few pure “efficiencies” left to be found in adult social care. Many efficiencies identified by councils now inevitably include an element of cuts to services or tightened eligibility criteria. Total savings stand at £2.68 billion over the last three years, a total of 20 per cent savings. The Government must exercise caution when assessing the scope for further immediate efficiencies, particularly as the requirement for immediate savings jeopardises longer-term efficiency programmes.

Our modelling for 2015/16 includes efficiency assumptions of 2 per cent (2013/14), 1.5 per cent (2014/15) and 1.5 per cent (2015/16). Assuming funding reductions continue along the 2010

Spending Review trajectory then this results in local authority projected income in 2015/16 accounting for approximately 85 per cent of estimated spend. Any government assumptions of further efficiencies will therefore leave a bigger gap that will have to be fixed by cuts. Adult social care would not be immune to this, which would exacerbate the pressures outlined above.

Reducing spending on prevention and early intervention is one of the only places left to look for further savings, this is counter to the policy direction set out in the care and support White Paper. It is only by **implementing effective integration across the country that we can expect to drive out further large scale genuine efficiencies from the health and care system. These are largely from reducing activity levels and social care supporting greater efficiency in the health service. The spending round should not deduct predicted "efficiencies" from the settlement for adult social care. Instead it should allow any efficiencies that can be secured to be reinvested in prevention and early intervention to drive out savings over time while securing improved outcomes for individuals and local communities.**

6. Integration

There is clear consensus that integrated care is a key priority and that this is where the real cross-system efficiencies are to be found. The integration and community budget pilots have shown that better outcomes for individuals and communities, as well as greater efficiency, can be achieved by shifting resources from acute hospital and institutional care into community based services. However, to achieve this requires changes in NHS and local authority activity and spend. It also requires simultaneous changes over several years in hospital configuration, GP services, community health and social care.
Short-term cuts in care capacity will imperil medium-term restructuring of services and costs and jeopardise service improvements and greater efficiency gains. Achieving sustainable integration and the benefits that flow from it will require place-based settlements and this should be signalled and invested in during the spending round.
One of the biggest potential areas for savings is through more effective care for individuals with long term conditions, most of whom are older people with a variety of needs that require an integrated response. Getting this right will avoid inappropriate hospital admissions and improve hospital transfers. Improving standards of health care could have a positive impact on the need for social care, for instance in the treatment of people with strokes, continence problems or dementia. Intermediate care could also be used much more effectively, for instance to treat continence problems in older people who leave hospital so that they do not need to go into residential care.

We are seeking a range of actions to support integrated care. These include:

- Working through perceived barriers, such as competition rules, to allow integrated care to be commissioned and delivered.
- More flexibility to enable local areas to use funding creatively, for example by substituting capitation for tariffs for some client groups.

- Supporting investment in integration. Small scale examples, such as reablement teams, have reduced hospital admissions and length of stay.
- Allowing front line staff to commit resources from different parts of the system to cover the costs of care coordination.
- Streamlining the lengthy and bureaucratic process of making formal arrangements for the NHS and councils to share budgets.
- Development of electronic records which requires significant capital and revenue investment; and above all
- Encouraging the leadership behaviours and culture change needed to work in an integrated way.

The learning from Community Budgets must be applied to the on-going work on integration in the context of wider adoption of the whole place approach across the country. Effective integration supported by community budgets should help to enable us to disinvest from acute care and reinvest in community support. This will release savings from the fact that there are a large number of people in hospital that do not need to be there and that there is further scope to avoid admissions to residential care.

Implementing the Community Budget model across the country is crucial to enable efficiencies from integrated services to be realised fully. Health and Wellbeing Boards need to be making the decisions and their role needs to be reflected in NHS managers' incentives. They are the place for local decision-making and where the needs of local communities can be properly addressed through a genuine whole systems approach that considers integrated assessments, commissioning, budgets and systems.

The transfer of public health to local government also presents great opportunities to improve integration for the whole population. Tackling obesity, for example, can help reduce the risk of mental health problems and a wide range of diseases. But this is not just about what councils can do. The incidence of obesity is considerably higher in individuals across all ages with a long term condition and it is clear that a joint approach will be most effective.

In carrying out their public health duties councils need to be adequately resourced and have the financial flexibility to develop new approaches to improving their residents' health. The two year settlement for public health was very welcome and will enable better local planning. This funding must continue and, over time, **government should consider ending the ringfence for the public health budget to enable a more effective approach to joined-up and integrated services. This would further embed an approach based around the whole system. With Health and Wellbeing Boards being the custodians of such a system, public health could be incorporated into wider local work on prevention – itself part of the solution to the pressure on health and social care spend.**

5. Conclusion

Adult social care has a strong history of being resilient and robust. However, these characteristics are now being tested to their limits. The spending round is an opportunity to address some of these issues and help drive a more integrated approach to make it more efficient and responsive. Central to this process must be a focus on integrated service models, an understanding of the extent to which the system can withstand further reductions, sufficient funding to deliver on an ambitious reform agenda and a better use of money across health and social care.

In light of the evidence provided above we believe that the ten integrated care pioneers should be active in areas where there is the greatest potential for improvement across the whole system locally. This would include improvement in terms of the individual's experience of integrated care, outcomes and reductions in activity resulting in financial savings. Councils in such areas are likely to be more dependent on grant funding and are therefore facing more grant reduction. This in turn means that health inequalities are likely to be greater and pressure on local health services more acute.

For more information please contact:
Matthew Hibberd
Senior Adviser
Local Government Association

Local Government House
Smith Square
London SW1P 3HZ

Email: matthew.hibberd@local.gov.uk
Telephone: 020 7664 3160

Contact the Local Government Association
Telephone: 020 7664 3000
Email: info@lga.gov.uk
Website: www.local.gov.uk