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Adult social care, health and wellbeing: A Shared Commitment

2015 Spending Review Submission

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Executive summary

Adult social care is critical to the health and wellbeing of people with a complex range of often intense needs, their carers and families, and our communities more generally.

Social care plays a key role in a sustainable NHS and its reach is significant; from safeguarding the most vulnerable to making an important contribution to the national economy.

In Distinctive, Valued, Personal, the Association of Directors of Adult Social Services (ADASS) set out why social care matters and presented a five-year vision for a social care system which is protected, aligned and re-designed.

In order to build a successful partnership between social care and health for years to come, both partners need to be sustainable and have stable foundations. While funding for health increased in real terms in each year of the previous Parliament, adult social care faced significant cuts despite councils diverting money from other budgets to protect essential services and increasing demand.

The Spending Review period will continue to present significant and increasing pressures within adult social care. They will be driven by:

- demand increases in both the volume and complexity of people's needs for adult social care
- reductions to wider local government funding
- the introduction of the National Living Wage (NLW) and absence of certainty of funding
- the reducing scope for further efficiency savings
- increased numbers of allegations of abuse and neglect
- availability and skills needs of the workforce.

On the basis of all of the factors outlined above, the Local Government Association (LGA) estimates that the funding gap facing adult social care is growing on average by just over £700 million a year, based on the current service offer and not taking account of many other pressures that are either already being felt or are likely to be felt in the coming months:

- In addition to the quantified pressure caused by the NLW on care provider contracts, there are further uncertainties about the impact of the policy on, for example, people who employ personal assistants (PAs) through a direct payment, or the provision of sleep-ins after recent changes to the current National Minimum Wage.
- The 2014 Supreme Court judgement has widened the scope of Deprivation of Liberty Safeguards (DoLS) well beyond anything assumed in the Department of Health's (DH) impact assessment. The Law Commission has estimated that the annual cost of achieving compliance is £172 million per year.[1]
- The Independent Living Fund (ILF) is an additional funding burden and we are disappointed that funding allocations are not yet clear.[2]
- The funding that councils received for winter pressures in the last financial year was in no way proportionate to the scale of the task or the level of support needed for vulnerable people. Councils must be funded adequately if they are to continue reducing pressures and costs for NHS during times of increased demand.

1 Impact Assessment – Mental Capacity and Detention, Law Commission, August 2015

2 Correct at time of writing.

- An anomaly in the financial means test means that some armed forces veterans are required to count their injury compensation monies as income while others are not, meaning that veterans injured before April 2005 have to pay for social care whilst those injured after do not.

Inevitably, the care market is becoming increasingly fragile, and this adds a further risk to the system. These risks are illustrated by high turnover of staff, suppliers leaving the market, and increasingly slim margins for those that remain, particularly in domiciliary care. These pressures are well evidenced and recognised among independent experts including the National Audit Office[3]. Funding for adult social care must keep pace with these growing demands and costs if we are to avert widespread market failure and the consequent impact on the lives of some of the most vulnerable members of our society.

Nevertheless councils remain ambitious and focused on positive action.

There is cross-party consensus within local government that integration of social care and health is the right approach, particularly to improve outcomes for citizens, but also because it may improve value for money in the long-term. Recent care and health reforms, the NHS Five Year Forward View and ADASS' Distinctive, Valued, Personal further cement this position and recognize the need for care and health systems to be locally led, with a stronger emphasis on prevention and more personalised services. The Spending Review is therefore a key opportunity to develop a more integrated and devolved approach to care and health.

The LGA and ADASS have consistently argued that there is a need for a separate transformation fund with the aim of implementing a new prevention strategy to drive real change. This would, in the short-term, enable local areas to spend money on new investment in preventative services alongside 'business as usual' in the current system, until savings can be realised and new ways of working become commonplace.

Preventing or delaying ill health amongst adults and carers is now codified in the Care Act. LGA research on a range of local prevention schemes suggests that investment in prevention could yield a net return of 90 per cent.

Despite serious concerns about the process, the introduction of the Better Care Fund (BCF) has marked an important change in how care and health interact in local areas with residents being placed at the heart of the change in services they receive from both councils and the NHS.

We support an expanded BCF but not as the primary means of protecting adult social care outcomes – closing the adult social care funding gap to make the service sustainable must be the first priority.

3 Adult social care in England: overview. NAO, March 2015

Our recommendations

Our shared aspiration is for better, more coordinated and more personalised care for people. This means people staying healthy, supported to live in their community and in control of their care and their lives. It means a social care system that is responsive to people's needs and seamless between different parts of this system. It means care that remains safe and of decent quality, protecting people from abuse and neglect. It also means care that delivers better outcomes for every £1 spent.

We share the Government's vision of integrated care and health services.[4] However, in order for social care and health to be able to achieve this shared vision both partners need to start off from a sustainable financial footing. Only when adult social care is funded appropriately can ambitious reforms succeed, as recognised by the Government in its decision to delay Phase 2 of the Care Act.

Mitigating the pressures outlined in this submission and ensuring a sustainable and well-functioning adult social care and support system will require:

1. Providing sufficient grant funding to close the social care funding gap that is already present in the social care system and growing on average by just over £700 million a year.[5] Until the system is stable enough to implement the delayed Phase 2 Care Act reforms, social care must be supported in the interim by releasing the earmarked funding into the care service through the settlement funding assessment (SFA), with the rest of the funding coming from reductions to spending on other Government departments.
2. Monitoring and funding in full all identified pressures and burdens, such as DoLS and wider pressures on the provider market and the workforce.
3. Introducing multi-year financial settlements to allow proper planning for service transformation alongside NHS partners.

4 Conservative Party pre-election manifesto, 2015

5 This analysis is based on the LGA's Future Funding Outlook model and thus represents the absolute minimum funding challenge. We have been intentionally cautious in how we have estimated the size of the funding gap so as to avoid criticism of overplaying the scale of the challenge.

For example, our assumptions on demographic pressure are based on a split between 'working age adults' (18-64) and 'older people' (65+). Deeper, segmented analysis – looking at the particular pressures posed by an increase in the over-85 and learning disability populations – would almost certainly increase the size of the funding gap significantly

Additionally, an assumption of a stronger pressure on external contract costs (eg tracking changes in private sector pay) could be legitimately applied. This would again increase the size of the funding gap by a considerable amount.

If adult social care is put on a sustainable foundation, integration of care and health can become more ambitious. To shift the focus of the system from crisis management to prevention and early intervention, and to support the shift of demand from acute care to primary and community care alongside social care, we propose:

4. Allocating £2 billion in each year of the Spending Review period to support service transformation across social care and health.
5. Using part of this fund to support investment in a more ambitious prevention strategy, which could generate a net return of 90 per cent over the next five years.
6. Strengthening health and wellbeing boards to become the system leaders for local care and health systems.
7. Expanding the scale of our ambition for integration through greater pooling and aligning of budgets. This should include an expanded BCF which learns from what has worked well to date and what hasn't, alongside the transformation fund mentioned above to complement local arrangements to maximise outcomes for people's health and wellbeing.

Introduction

Adult social care is critical to the health and wellbeing of people with a complex range of often intense needs, their carers and families, and our communities more generally. Through commissioning social care, councils play a key role in a sustainable NHS and its reach is significant; from safeguarding people in the most vulnerable circumstances to making an important contribution to the national economy as employers and commissioners.

In its pre-election manifesto, the Government recognised that integrating adult social care and health is a priority. We agree – councils and the NHS need to work together to ensure that vulnerable members of our society continue to receive the help and support needed to live fulfilling and independent lives.

However, securing a better care and health system isn't just about integration.

The social care funding gap and associated budget cuts affect a wide range of people connected to the care and support system, sometimes severely. Restricted funding is the main reason for people being not being able to access the care system as services cease or become increasingly rationed. This leads to:

- concerns about the duration and quality of care that people receive
- carers compromising their own health, careers and retirement prospects
- a genuine threat to the viability of provider businesses and the people that constitute the social care workforce
- the challenges facing the NHS being exacerbated with people presenting to A&E unnecessarily or being delayed in returning to the community from hospital.

These are national implications – but the solutions lie locally.

If the Government works with us by acting on the proposals in this submission then we can do what we do best and help to maximise people's quality of life and support their wellbeing and independence.[6] With the right resources, the right emphasis on prevention, and the right mechanisms for greater integration, councils will be more able to:

- lay the foundation for supporting people who are at greatest risk of not having their essential needs met
- further embed personalisation so that people have real choice and control over the support they need to improve outcomes
- invest more heavily in preventative services that help keep people healthy and out of both the formal care system and the health service, reducing the demand and cost pressures on the NHS at the same time
- properly support the thousands of informal carers who play a vital role in sustaining our care and support system
- support the sustainability of the NHS, which is struggling under the weight of its own set of unique and extreme pressures
- continue to support social care's contribution to economic growth. Most care providers are small businesses that form a sizeable chunk of the local economy in many places. It contributes as much as £43 billion to the national economy and supports 1.5 million full time equivalent jobs

6 For a fuller treatment of why social care matters see, 'Distinctive, Valued, Personal', ADASS, March 2015.

- prepare to fully implement Phase 2 of the Care Act, building on a strong base of sustainable services.

The Government's manifesto commitment to integrate social care and health using the BCF as a key mechanism is a step in the right direction. But in committing only to invest additional money in the NHS (maintaining the current tariff) – and not social care – there is a risk, at best, of perpetuating the pressures facing adult social care and support, and at worst, pushing the whole social care system into crisis with profound knock-on effects to individuals and their families, other local government services, the NHS and local communities.

This submission makes the case for a care and support system that is viewed and valued in its own right. It presents social care, and the local government environment in which it sits, as a central part of the solution to how we, as a nation, create an overall care and health system that delivers for people and is a world leader in integrated social care and health. We recognise that there is variation within the social care and support system but argue this should not necessarily be viewed as a negative; this is 'postcode choice' in action as local areas respond to local circumstances decide for themselves how best to meet the needs of their residents and target resources towards greatest need in partnership.

Finally, ensuring adequate and fair funding for adult social care is central to the sustainability of local government overall. Net spending on adult social care typically accounts for 35 per cent of net council spending on core services, a rise from 30 per cent in 2010/11.[7] This follows concerted efforts within social care to make savings, and for many that means there are few places left to turn to make additional efficiencies.

As set out later in the paper, other council services have been making a disproportionate share of savings in recent years to keep spending on the care system under control. This has been felt most strongly in councils which spend proportionately more on adult social care. The benefits of funding adult social care sufficiently therefore accrue not just to people who use social care services, but to anyone who accesses local government services. It is essential that Government recognises this connection: sustainable social care will help deliver sustainable local government services.

7 ADASS Budget Surveys, 2014 and 2015

Adult social care during the previous Parliament

KEY POINTS

In order to understand the underlying pressures within adult social care, it is important to revisit the experience of the past five years.

The 2010 Spending Review (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, new LGA analysis shows councils had to deal with a £5 billion funding gap in adult social care services. They were successful in doing so – but only by reducing other service budgets by £2.5 billion in return and by imposing savings and service reductions of the same magnitude within adult social care.

As set out in the LGA and ADASS report, 'Adult social care funding: 2014 state of the nation'[8], spending on adult social care over the last Parliament was kept under control through a combination of savings, service reductions including pressurised children's services, additional funding from the NHS and cuts to other local government budgets. We revisit this analysis nearly a year later.

In the 2010 SR the previous 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.

It argued that this money, when combined with efficiency savings, was sufficient to prevent a funding gap for social care over the SR period.

This may well have had a positive impact if councils were operating in a steady financial state overall. However, local government faced unprecedented cuts over the last Parliament and core grant funding was reduced by 40 per cent in real terms.

As part of the measures to close the gap, other council services had to absorb £2.5 billion of reductions above the trend that general council funding changes would imply.

Each council will have made their own spending decisions but it is safe to assume that a number of the 'other council services' affected will have been those that contribute to people's wider wellbeing, such as libraries or leisure. These are preventative services in the widest sense, and part of any local area's strategy to keep people fit, healthy and independent. The number of people aged 65 and over is also growing significantly – an increase of 11.4 per cent between 2010 and 2014 alone.

8 Adult Social Care Funding: 2014 state of the nation report, October 2014

Table 1. Adult social care funding gap, 2010-2015

	£bn 2010/11	£bn 2011/12	£bn 2012/13	£bn 2013/14	£bn 2014/15 budget	£bn 2015/16 budget (provisional)
Cost pressures (gross of NHS transfer and Better Care Fund)	14.4	15.3	16.3	17.2	17.8	18.4
Less: Core funding	14.4	13.6	13.1	12.8	12.3	11.6
Less: Joint initiatives with the NHS (NHS transfer, BCF including Care Act)	0.0	0.6	0.6	0.9	1.1	1.9
Funding gap	**0.0**	**1.1**	**2.6**	**3.5**	**4.4**	**5.0**
Met through:						
Savings	0.0	-0.1	1.2	1.8	2.3	2.5
Money diverted from other council budgets	0.0	1.2	1.4	1.7	2.1	2.5
Total	0.0	1.1	2.6	3.5	4.4	5.0

Cutting wellbeing services to help protect services for people with high levels of need, or those who are facing a crisis, is intuitively counter-productive; it is a short-term fix that results in needs growing unchecked or unmet until more intensive and high cost social care services are required.

This is not the approach councils want to take, but it is the situation they find themselves in because they have to prioritise statutory services. It is also counter-productive in terms of the negative impact it has on the NHS. The £200 million reduction to the public health grant as part of the July Budget is a false economy in the same way.

The impact of the path of social care funding is more pronounced when set against the number of people reaching out to access services: in 2013/14 there were 2.16 million contacts from new clients, a 4 per cent increase from 2012/13, and this is before the new duties under the Care Act which began earlier this year. The number of people aged 65 and over is also growing significantly - an increase of 11.4 per cent between 2010 and 2014 alone.

The relative protection of adult social care cannot mask the fact that there was, and remains, unmet need within the system.

The National Audit Office has recognised[9] this:

"Pressures on the care system are increasing. Providing adequate adult social care poses a significant public service challenge and there are no easy answers… need for care is rising while public spending is falling, and there is unmet need. Departments do not know if we are approaching the limits of the capacity of the system to continue to absorb these pressures"

And furthermore:

"Safeguarding vulnerable adults from abuse and neglect remains a major risk throughout the sector. Between 2010/11 and 2012/13, safeguarding referrals recorded by local authorities rose by 13 per cent. Though this increase may reflect increased awareness of abuse, it may reflect overstretched resources and pressure within the system."

9 Adult social care in England: Overview. National Audit Office, March 2014

The additional and significant savings requirement for 2015/16 further fuels concerns about unmet need. A 2013 LSE report commissioned by the Care and Support Alliance showed that 500,000 older and disabled people who were not receiving social care in 2012 would have done so five years earlier as a result of tightening eligibility criteria during this period.[10] More recently, research by Age UK revealed that more than one million older people have unmet social care needs, which includes support with basic tasks such as getting out of bed, washing and dressing.[11]

This is clearly not what councils want to see. But with any 'easier' savings having now been made the inevitable reality is that people's access to support is being increasingly restricted. And, of course, many unmet needs will simply escalate to the point at which people do qualify for council support, meaning more people presenting with complex or multiple conditions.

Councils fully understand the importance and benefits of investing in prevention – and it is now codified in the Care Act. However, overall funding pressures are resulting in planned spend on preventative measures dropping from £937 million in 2014/15 to £880 million in 2015/16 – a 6 per cent reduction in cash terms.

The latest stocktake of councils' progress with Care Act implementation also shows that 'prevention' has become an area where support is needed; this was cited by 37 per cent of councils – up from 29 per cent in the previous stocktake.

10 Changes in the patterns of social care provision in England: 2005/6 to 2012/3, LSE, December 2013

11 'Over a million older people struggling to cope', Age UK, June 2015

A comparison with the NHS

There are clear links and dependencies between social care and health, yet the way each is treated – particularly in funding terms – could not be more different or unequal.

The funding squeeze on adult social care over the 2010 SR period contrasts sharply with the NHS, which has received real terms protection of its spending over the same period. Health funding has increased from £97.5 billion in 2010/11 to £116.4 billion in 2015/16, an increase of 19.3 per cent. And, of course, while councils have continued to produce balanced budgets, NHS Trusts have run major deficits and seen productivity fall since 2012.[12]

In 2014/15 NHS Trusts reported a deficit of £822 million, significantly higher than the £115 million deficit in 2013/14.[13] Latest financial performance information from Monitor shows that, for the first time, Foundation Trusts ended the year with a net deficit of £349 million against a planned deficit of £10 million in 2014/15.[14] This was £475 million worse than 2013/14. These deficits are offset by surpluses elsewhere in the health system. However, latest data shows that DH underspent its revenue budget by just £1.2 million in 2014/15, suggesting the Department is at significant risk of having a deficit year in 2015/16.

Trying to compare approaches to budget management between social care and health is inevitably difficult given the operational differences between each side. Foundation trusts, for example, can set deficit budgets whereas councils are required by law to set a balanced budget.

12 A mountain to climb for NHS Finances, Health Foundation, April 2015

13 'NHS Trusts' deficit rises to £822 million', BBC, May 2015

14 Quarterly report on the performance of the NHS foundation trust sector: year ended 31 March 2015, Monitor, May 2015

This requirement on councils, allied to their strong record on accountable and robust budget setting and managing efficiencies whilst still improving services and satisfaction levels, means that local government is an 'easy target' for further savings. We believe there is much that the NHS could learn from local government on the efficiency agenda.

Then and now: what the ADASS budget survey tells us

The ADASS Budget Survey, which enjoys a response rate close to 100 per cent, has become a respected and widely referenced annual overview of adult social care expenditure and financial pressures. While the methodology used for the ADASS Budget Survey is different to the LGA's analysis elsewhere in this paper, the results provide a valuable insight into the year-on-year financial trends and the mood and perceptions of leaders in adult social care at the earliest possible point after the end of the budget planning cycle.

Between 2011/12 and 2014/15 responses to the ADASS survey indicated councils had made adult social care budget savings of 26 per cent, worth £3.53 billion. Further, it showed that councils are planning additional savings worth £1.1 billion in 2015/16.

Cumulative savings of £4.6 billion reported by ADASS break down as: service reductions of £1.6 billion, management of increasing demand worth £1.75 billion, and management of price pressures worth £1.25 billion. In 2015/16 18 per cent (£192 million) of the £1.1 billion savings requirement will be met from reducing services and 28 per cent (£228 million) will be met from reducing the volume of care packages.[15]

Less than half of directors of adult social services surveyed by ADASS are fully confident that planned savings for 2015/16 will be met (45 per cent). Of greater concern, confidence levels drop significantly when looking ahead to the next two years; just 7 per cent of directors are fully confident of meeting savings requirements in 2016/17, with 5 per cent fully confident for 2017/18.

Directors are clear about the impact of these savings and again believe the next two years will be more difficult than now. Comparing the impact of savings made to date and the impact in two years' time, directors believe that:

- fewer people will be able to access services
- personal budgets are and will continue to become smaller
- there will be increased pressure on the NHS
- quality of care will become lower
- providers will be facing financial difficulty
- there will be more legal challenges.

Savings are driven in part by demand increases. The ADASS survey also shows that demographic pressures will continue to run at around 3 per cent, equating to £350 million additional costs in 2015/16. Councils plan to fund 76 per cent of this pressure – down from funding 83 per cent (of a £400 million pressure) in 2014/15.

15 ADASS budget survey 2015 report', ADASS, June 2015

The future funding gap

KEY POINTS

With adult social care budgets already working on the basis of a pre-existing £5 billion funding gap, there are further significant challenges to come during the rest of the decade.

LGA analysis of future demand pressures, inflation, funding reductions implied by the Summer Budget and the NLW shows that the funding gap is set to continue to grow by an average of just over £700 million a year over the Spending Review period.

As a down payment for a sustainable partnership between care and health, this gap should be funded in full. Until the system is stable enough to implement the delayed Phase 2 Care Act reforms, social care must be supported in the interim by releasing the earmarked funding for the reforms into the care service through the settlement funding assessment (SFA), with the rest of the funding coming from reductions to spending on other Government departments. Funding arrangements should be fixed for several years to allow councils to plan services better, including with NHS partners.

Ultimately, it is apparent that different stakeholders in the social care sector, including the Government, have a different view on pressures facing councils. We would therefore propose a joint working group, involving the LGA, ADASS, the Government and other stakeholders in the social care sector to establish a joint understanding of future challenges in both adult and children's social care.

A number of further financial pressures, including DoLS assessments, are causing uncertainty to vulnerable people and councils and should be addressed. We discuss them later in the paper.

The funding gap

Latest analysis shows increasing pressures year on year, driven by increasing demand, cuts to wider local government funding, inflation and the introduction of the NLW. We estimate that the funding gap facing adult social care is growing on average by just over £700 million a year.[16]

Taking the analysis of the historic and projected funding gaps together shows that between 2010/11 and 2019/20 adult social care will have faced a funding gap of £7.9 billion.

16 The estimate of the funding gap includes assumptions about pay; both a 1.4 per cent base increase in pay and the impact of the National Living Wage.

Table 2. Adult social care funding gap, 2016-2020

	£bn 2016/17	£bn 2017/18	£bn 2018/19	£bn 2019/20
Cost pressures:				
Core demand/inflation pressures	0.2	0.5	0.7	1.0
National Living Wage pressures	0.3	0.5	0.7	0.8
Home care contract pressures in relation to current minimum wage	0.3	0.3	0.3	0.3
Total cost pressures	**0.8**	**1.2**	**1.7**	**2.1**
Add: Reduction in core funding	0.1	0.5	0.8	0.8
Total expected additional gap	**0.9**	**1.7**	**2.5**	**2.9**

Figures may not sum due to rounding

Adult social care has already made major efficiencies and the scope for more is now limited. The LGA's estimate of the future funding gap assumes that councils will make 1 per cent efficiencies each year. It is extremely difficult to predict what level of efficiency may be achievable and the scope for further savings will vary from council to council.

We acknowledge this variation but it should not be used as a rationale to conclude that significant scope for savings remains. We are happy to continue discussing this with the Government in the run-up to the Spending Review.

However, councils – which have a strong track record on the efficiency and innovation agendas – have already made extensive savings since 2010. Consequently, and as the ADASS budget survey shows, service reductions, smaller care packages and rising user charges are becoming the primary means of managing continued savings requirements (rather than, for example, savings from streamlining back office functions).

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 table 3).

This analysis is based on the LGA's Future Funding Outlook model and thus represents the absolute minimum funding challenge.

We have been intentionally cautious in how we have estimated the size of the funding gap so as to avoid criticism of overplaying the scale of the challenge.

For example, our assumptions on demographic pressure are based on a split between 'working age adults' (18-64) and 'older people' (65+). Deeper, segmented analysis – looking at the particular pressures posed by an increase in the over-85 and learning disability populations – would almost certainly increase the size of the funding gap significantly.

Additionally, an assumption of a stronger pressure on external contract costs (eg tracking changes in private sector pay) could be legitimately applied. This would again increase the size of the funding gap by a considerable amount.

Meeting the funding gap and the Care Act

The LGA and ADASS have welcomed the Government's decision to delay Phase 2 of the Care Act. It is disappointing to see these vital reforms delayed, but it is necessary given the fragile financial situation of councils. We fully support the aims of the reforms and look forward to them being implemented when social care services become more sustainable.

Table 3. Phase Two Care Act funding and the funding gap, 2016-2020

(£bn)	2016/17	2017/18	2018/19	2019/20
Underlying gap	0.9	1.7	2.5	2.9
Earmarked Care Act phase two funding	0.7	0.7	0.8	1.2
Remaining gap	**0.2**	**1.0**	**1.7**	**1.7**

We have consistently supported the need for changes to the way people pay for their care and still believe this to be necessary. The aim of limiting people's exposure to potentially catastrophic care costs is extremely important.

However, we have taken a pragmatic view that, if Government was unable to fund both the system and the reforms, then absolute priority must be given to the sustainability of the system itself. This was recognised by the Prime Minister.[17]

A delay with no money – while helpful in terms of buying the sector more time to model costs and prepare regulations and guidance – will not address the primary problem of inadequate funding for social care. The Government must set out at the earliest opportunity how it will reinvest earmarked monies back into the system until such a time that the social care system becomes sufficiently sustainable to deliver the reforms.

However, that sustainability will only be achieved in the short term (and then only partially) if the earmarked monies for Phase 2 are put back into adult social care system. As the table above shows, releasing the funding would still leave a funding gap of £1.7 billion by 2019/20. Ultimately, reductions to funding to central government departments would have to take place in order for the gap to be closed permanently and in full.

Learning disabilities

Demographic pressure is not just an issue of increasing numbers of older people, often with more complex needs – for some councils the pressure posed by the numbers of people with a learning disability, at least in financial terms, is as high as that posed by the increasing numbers of older people.

The trend of reduced spending related to older people's and physical disability and sensory impairment services is not reflected in spending related to learning disabilities, and mental health spending has risen (Audit Commission 2013). In 2013/14, social care for working-age people with learning disabilities accounted for 31 per cent of gross current expenditure on social care, or £5.4 billion and it is expected that this will continue to increase.

Department for Education (DfE) data suggests that the number of pupils with learning disabilities is expected to increase by 26 per cent from 2014 to 2023, more than double the speed of increase in overall pupil numbers. It is therefore expected that despite legislative and policy changes, spend on children with learning disabilities who will then require ongoing and intensive care and support from adult social care is likely to continue to increase.

Learning disability services can be expensive relative to wider adult service costs and thus even a small increase in activity can generate significant costs for local councils.

17 'David Cameron Vows to Cap the Crippling Cost of Care Homes at £72,000 Despite Fears of Four-Year Delays', Daily Mail, August 2015

Other pressures on adult social care

KEY POINTS

In addition to the core funding challenges set out above, there are a number of other pressures that need to be funded to ensure that the most vulnerable people in society can continue to receive high quality adult social care services:

- The 2014 Supreme Court judgement has widened the scope of DoLS well beyond anything assumed in the DH's impact assessment. The Law Commission has assessed that achieving compliance with the law would cost £172 million per year to local authorities for decisions within the DoLS framework alone.
- The ILF is an additional funding burden and we are disappointed funding allocations beyond the current year are not yet clear at the time of writing.
- According to the ADASS Budget Survey, councils received only 5.9 per cent (£41 million) of the £700 million allocated to the NHS to respond to winter pressures in 2014/15. This money, even with the additional £37 million councils received directly to help tackle delayed transfers of care, was in no way proportionate to the scale of the task.
- While we are able to quantify the pressure on care providers, the impact of the NLW and changes to pension provision on people who employ PAs through a direct payment remains uncertain. There is also pressure due to paying for sleep-in arrangements under recent changes to current National Minimum Wage.
- An anomaly in the financial means test means that some armed forces veterans are required to count their injury compensation monies as income while others are not, affecting their accessibility to adult social care where circumstances might actually be similar.

On the basis of increasing demand, inflation and the NLW commitment outlined above, we estimate that the funding gap facing adult social care is growing on average by just over £700 million a year.

However, this is based on the current service offer and does not take account of other pressures that are either already being felt or are likely to be felt in the coming months. We discuss them below.

The National Living Wage (NLW)

Since 2010 providers have been under increasing pressure as councils have been forced to limit fee level increases in response to reduced funding and calls for value for money from central government. The introduction of the NLW will exacerbate these pressures and there are real concerns about the viability and sustainability of some providers within the care market.

The Chancellor's announcement in the Summer Budget of the NLW, rising to at least £9.00 an hour by 2020, is a welcome and important development.

However, the NLW will have significant financial implications for councils and will not start from strong foundations. The UK Home Care Association[18] has published a target 'fair' rate of £15.74 per hour for contracted home care services in 2015/16, based on the current National Minimum Wage. ADASS analysis shows that councils would face a cost of £278 million were they to pay this rate for all their home care contracts, indicating a significant pre-existing pressure.

LGA analysis shows that introducing the NLW for all council employees will cost £7 million in 2016, growing to £111 million by the end of the Spending Review period. The largest pressure will be felt through commissioned services, notably social care.

In terms of residential and home care contracts we estimate the pressure to be worth £330 million in 2016/17, growing to £834 million by 2019/20.

Concerns about the impact on councils and providers of the change are shared across the sector.[19]

Some of the impact of NLW is more difficult to measure. For example, from June 2015 individuals hiring PAs through a direct payment or personal budget will be required to meet the PA's relevant pension costs. It is difficult to know how many people will be affected by this change but this will pose an additional pressure on the system – particularly given that 58 per cent of directors of adult social services believe that personal budgets will get smaller over the next two years.[20] There is also the potential for people to be discouraged from hiring PAs because of the possible increase in cost and paperwork.

This pressure on personal budgets and direct payments may also be exacerbated by the NLW if people receiving these packages to arrange their care are required to cover the costs of the NLW for PAs.

Pressures on the provider market and the duty to arrange care

Provider fees already cannot be squeezed much further. Directors of adult social services report that only £32 million of efficiencies will be found through this route in 2015/16, equivalent to just 3 per cent of the overall savings target.

Fifty six per cent of directors believe that providers are facing financial difficulties now (rising to 62 per cent when considering what the situation will be like in two years), fuelling wider concerns about provider viability and sustainability and the quality, quantity and duration of commissioned care.[21] Some providers have already left the market and others are moving to a quality (and higher priced) model only.

18 A Minimum Price for Home Care. UK Home Care Association (UKHCA), July 2015

19 See, for example, 'Knock on effects of the budget could hit social care hard', Laing and Buisson, July 2015

20 'ADASS budget survey 2015 report', ADASS, June 2015

21 'ADASS budget survey 2015 report', ADASS, June 2015

There has been growing concern that the 'duty to arrange'[22] could result in significant further funding pressures on the care system. Currently, councils tend to pay lower fees than self-funders due to their bulk-buying power.

With the difference between council and self-funder rates made more transparent it is likely that either providers will have to accept and absorb lower fees or councils will have to increase their rates to providers. Neither option is sustainable.

The County Councils Network (CCN) report, 'County Care Markers: market sustainability and the Care Act',[23] shows that the current (2014) 'care home fee gap' stands at £236 million just for the 12 councils who were part of the CCN study, or £630 million if extrapolated for all 37 CCN members.[24] Even with the delay to the 'duty to arrange' CCN still expect the care home fee gap to increase over the coming years.

Part of the difference between council and self-funder rates is reasonable given the benefits associated with councils' bulk purchasing of care. However, we fully acknowledge that a sizeable and unsustainable gap still exists and must be addressed. Existing CCN figures are significant – but in order to fully understand potential national costs, an urgent analysis by the DH is needed.

Given the concerns it is helpful that the Government has delayed this element of the Act to allow time to better understand the cost implications involved. The results of this work need to be shared at the earliest opportunity.

22 Under the Care Act, and now from April 2020, a self-funder will be given an Individual Personal Budget that sets out what their council would pay to meet their assessed needs (which then contributes to the cap on care costs). This will make more transparent the difference between self-funder rates and council-funded rates. The duty to arrange allows self-funders to request that their council, for a fee, arranges their care and there is an expectation that self-funders would request that they pay the council rate.

23 County Care Markets: market sustainability and the Care Act, Council Councils Network, July 2015

24 The 'care home fee gap' is the difference between the 'care cost benchmark' (the Laing and Buisson benchmark fee level that balances sustainable cost and sufficient margins) and weighted average fees, multiplied by the number of residents. In short, it is the amount required to achieve market sustainability without resorting to self-funder cross-subsidies.

DoLS

It is right that people's ability to make decisions for themselves is preserved wherever possible, even in the most vulnerable circumstances.

However, the 2014 Supreme Court judgement on DoLS has widened the scope of safeguarding under the legislation well beyond anything assumed in DH's impact assessment, resulting in additional costs to local authorities of conducting assessments. The Law Commission has estimated that the annual cost of achieving compliance is £172 million per year.

Total costs must be funded under the new burdens doctrine.

DoLS are part of broader legislation brought in to protect the rights of people who lack mental capacity to decide where they are accommodated to receive care or treatment. The safeguards are intended to make sure that people are looked after in a way that does not inappropriately restrict their freedom. We support the reform as we believe it is the right thing to do. Unfortunately, the legislation used to implement the reform was flawed.

A Supreme Court judgement made on 19 March 2014 widened the definition of a 'deprivation of liberty' resulting in councils having to apply the safeguards to a much larger group of adult residents. This widening of scope goes well beyond anything assumed in the Department's original impact assessment and therefore constitutes a new burden.

In particular, following the Supreme Court judgement, councils have seen a substantial increase in the number of people requiring an assessment. Latest data shows that 142,902 assessments were carried out in 2014/15. Funding is based on the Government's estimates of costs and numbers.

Central to the Government's estimate was an assumption that the number of assessments would decline. The difference between projected numbers, as per the Department's 2009 impact assessment, and actual numbers receiving an assessment last year was 133,902.

As funding is based solely on the Government's estimates of assessment costs it does not accurately reflect the wider expenditure on providing the required service. The cost to the sector needs to be seen in this way, reflecting, for example, the costs of awareness raising, mediation, DoLS audits of managing authorities and reviews of the DoLS Supervisory Body. This increased cost was accepted by Government in the transfer of responsibility for hospital DoLS cases in 2013 but not for the greater number of applications in care homes.

We know that for some adult services departments DoLS constitutes a particular concern and exacerbates capacity pressures, particularly around workforce. The Law Commission's impact assessment found that proper implementation of the existing legal system to authorise deprivation of liberty would cost local authorities £172 million a year for authorisations within DoLS alone.[25]

The Government has made a one-off payment of £25 million for this financial year but this still leaves a shortfall of almost £150 million in 2015/16 that councils should not be expected to absorb (and without new funding will be met by further reductions to other council services). This figure reflects statutory DoLS applications only.

The huge increase in resources needed to fulfil the actions required to authorise deprivation of liberty in settings outside of hospitals and care homes (Community DoLS) is not yet quantified. The courts are to collect data on this and there is currently no mechanism to fully assess the cost burdens of Community DoLS on councils or their partners.

We would like to work with Government to collect further information to accurately assess the true cost burdens of Community DoLS and the proposed changes to DoLS currently being consulted on, with a commitment that any financial burden be fully funded.

Changing the timeline of the Law Commission's review of DoLS is welcome, as is the additional payment. But neither fully mitigates the impact of current in-year DoLS pressures and recurring costs and we have yet to understand whether proposed new safeguards will be cost effective or to study in detail the Impact Assessment.

The lack of funding is resulting in people going without the full protection of the assessment and authorisation process; the main aim of the Safeguards – to protect people's rights and lawfully authorise deprivation of liberty – is therefore no longer achievable or deliverable.

Independent Living Fund (ILF)

The ILF was closed to new applicants from December 2010 and formally wound up on 30 June 2015 with funding for existing recipients transferring to councils through a Section 31 grant. Since 2010, councils have thus experienced demand pressures in relation to cases that would have been eligible for ILF support and are working hard to make the transition of the remaining ILF caseload as smooth as possible. However, as the Government's own publication on the closure of the fund states:

> "It is almost certain that closure of the ILF will mean that the majority of users will face changes to the way their support is delivered, including the real possibility of a reduction to the funding they currently receive".[26]

This is an additional funding burden for councils and one that councils do not yet have any certainty on, in terms of funding. In 2014/15, the Government spent £271 million on the ILF, yet the allocations for local authorities have not been announced and we expect the new burden to be funded in full in this year and beyond.

25 Impact Assessment – Mental Capacity and Detention, Law Commission, August 2015

26 Closure of the Independent Living Fund, DWP, March 2014

Councils will be doing all they can to assess former ILF recipients. But with funding still not confirmed not all councils will have been in a position to conduct assessments and determine how much support individuals will receive.[27]

Councils have already been taking on additional assessment responsibilities to comply with the DoLS judgement and can only move as fast as finances allow. In this context, a straight transfer from ILF to councils may not recognise that people's needs have increased.

This is a further example of the need to reform adult social care funding; small separate pots of money being allocated in different ways is not an efficient or effective way of getting care and support to those who need it most.

Winter pressures

Earlier this year councils demonstrated the vital role they play in helping the NHS to manage seasonal demand pressures. Councils were engaged in a range of activities to help combat delayed transfers of care, such as through six and seven day working, reallocating social work capacity to hospitals to support discharge nurses, increasing reablement support services, commissioning additional 'step-down' care home beds to get people out of hospital, and purchasing additional home care capacity.

The Government allocated £25 million of funding to 65 councils experiencing particularly high levels of delayed transfers and a further £12 million to all remaining councils. This level of funding is not proportionate to the size of the task – particularly when set against the £700 million Winter Resilience funding for health (5.9 per cent of which also went to councils, according to the ADASS Budget Survey). Councils must be funded adequately if they are to continue supporting the NHS during times of increased demand.

27 Correct at time of writing

A comparison with the NHS

Clearly it is not just adult social care that is in a perilous financial state. There is ample evidence that the NHS is heading towards financial crisis and the Government has committed to investing an additional £8 billion a year in the NHS by 2020. This allocation was made on the basis of the NHS committing to £22 billion of savings by 2020 as well – but recent reports already suggest this additional money will almost certainly not be sufficient and that a further £7 billion will be needed in order to maintain standards of care.[28]

However, there is no such commitment for social care and the example of winter pressures shows the unequal nature of social care and health funding. Councils received £37 million in 2014/15 to help combat pressures, compared to £700 million available to health through the Resilience Fund. If councils are to continue supporting the sustainability of the NHS and helping to reduce hospital admissions then adequate and proportionate funding for social care must be made available.

This is not just about winter pressures, but seasonal and year-round pressures as well. A properly functioning NHS relies on an adequately funded social care system to keep people out of hospital in the first place; it is a false economy to just invest in the NHS. The interdependencies between care and health are recognised by senior health colleagues, such as NHS England Chief Executive Simon Stevens.[29]

28 See, for example, 'NHS 'will fall well short of £22 billion savings target'', The Guardian, July 2015

29 Speaking at the March NHS England Board, Simon Stevens said: "When the much-heralded £8 billion [NHS funding gap] figure that people have inferred from the Forward View is talked about, one of the important provisos for that was that there was not a substantial offset in the availability of social care across the country. And to the extent that is the case that will, of course, produce more demand in the NHS. We have a shared agenda for ensuring that social care and health is contemplated in the round as we go into the next five years and the next Parliament."

A recent survey conducted for the NHS Confederation shows a similar message, with 99 per cent of more than 300 senior NHS managers and directors polled warning that cuts to social care are putting additional pressure on the health service.[30]

Provider Market and Workforce

ADASS' Distinctive, Valued, Personal, the NHS Five Year Forward View and the BCF all emphasise the need to develop a workforce with the right skills, values and behaviours to work across new models of care that span traditional professional boundaries, to better empower service users and communities and to shift resources and provision to more preventative approaches.

However, there are real concerns about capacity pressures on the adult social care workforce as demand for services increases while the profile, status and pay of the sector all remain low.

It is currently estimated that the number of jobs in adult social care that may be needed to meet the future social care needs of adults and older people in England is projected to grow by between 15 per cent and 55 per cent between 2013 and 2025. In the meantime, the turnover rate in adult social care is 25.4 per cent, with around 300,000 workers leaving their role every year.

Current severe difficulties in recruiting across a wide range of care and health roles are partly due to a lack of properly planned investment in education and training but also because wages and terms and conditions are generally poor or uncompetitive. Sufficient levels of funding across social care and health are an important prerequisite to improved recruitment, retention, training and rewards.

Recent valuable research by Bournemouth University, commissioned by the Borough of Poole,[31] shows that care sector employers and employees report a range of factors which negatively impact upon staff recruitment and retention. These include:

- lower levels of payment for private sector provision translating to lower levels of pay available to staff, which in turn shapes the ability of providers to recruit a good standard of staff, retain them and offer them appropriate progression opportunities
- increasing demands on staff due to the growing complexity of both service users' needs and regulation
- lack of flexibility in contracts
- the perceived vulnerability of staff and culpability should an unexpected safeguarding issue arise
- negative media representation of the sector
- the evaluation also found that young people are reluctant to consider careers in the care sector, which is a particular concern giving the sector has an ageing workforce.

It is not clear how the current state of the provider market can be reconciled with the need for a significant increase in the number of care workers in the future, let alone the introduction of NLW described above.

Instability within the care market is creating increasing risk. The announcement of the new NLW precipitated a fall in the share prices of care providers and a pause in lending from some lenders, many citing the absence of funding to meet increased costs in a sector where approximately 75 per cent of employees are on or very close to the existing national minimum wage. There remains further uncertainty about the arrangement of sleep-in provision which will increase costs.

30 NHS cannot take more cuts to social care, say healthcare leaders, The Guardian, June 2015

31 Pathways to recruitment: perceptions of employment in the health and social care sector, Bournemouth University, May 2015

We have seen increased signs of distress from the market in recent months including major providers disposing of supply that is funded predominantly by councils and the NHS, some suppliers exiting the market and others writing business value down to zero. Margins in the domiciliary care sector in particular are so slim that capacity is becoming increasingly limited as highlighted in some areas of the country over last winter and the consequent impact on the NHS.

Staff turnover is some 20-22 per cent across the sector (32 per cent for nurses working in nursing homes), the regulatory regime is identifying increasing numbers of serious concerns – 8 per cent of providers inadequate, 34 per cent requiring improvement and is taking a significantly increased amount of enforcement action.

In such a labour intensive sector, where demand is growing in both volume and complexity, it is inevitable that the scale of funding reductions to adult social care (31 per cent in real terms over the last Parliament) will have a direct impact on the price paid for and the availability and sustainability of local care and support services. Labour costs will increase further as a result of increased competition for staff as the economy strengthens and the welcome NLW. Funding for adult social care must keep pace with these growing demands and costs if we are to avert widespread market failure and the consequent impact on the lives of some of the most vulnerable members of our society.

Prices have been pushed so low that domiciliary care providers are under acute pressure. Most staff are paid near minimum wage but the advent of the NLW will drive prices up. To make contracts viable, staff are put under pressure to keep visits short with tight allowances for travel time. HMRC is investigating pay rates to ensure adequate payment for travel and breaks which will also push costs up alongside the clarified requirement to pay for sleep-in duties.

Given the pressures on pay, deterioration of services is likely – the number of allegations of abuse in care homes in 2015 is double that in 2011.

The Chancellor's announcement to reduce tax credits as part of addressing the root causes of low pay may also impact on the workforce. To the extent the policy will drive up employer wages the impact will be direct, but there may also be an indirect impact as wages increase in alternative areas of employment, such as retail. This will make adult social care work even less attractive as the sector cannot compete on pay given the overall funding landscape.

Armed forces compensation

Under current arrangements there is an unfair and unhelpful anomaly in the way that armed forces veterans' compensation monies are treated in the financial means test which is at odds with Government policy and commitment to supporting our forces veterans.

Veterans injured on or after 6 April 2005 receive compensation through the Armed Forces Compensation Scheme (AFCS). The AFCS pays a lump sum to all recipients and a non-taxable payment for life (the Guaranteed Income Payment, GIP). This funding is exempt from the social care financial means test.

However, veterans injured on or before 5 April 2005 receive a War Disablement Pension (WDP) and only the first £10 of this money is disregarded, with the rest regarded as income in the financial means test.

As the Royal British Legion (RBL) note:

"Parity between AFCS GIPs and War Pensions has already been achieved in relation to Universal Credit, which rolls six different benefits into one payment. The means testing process for UC will fully disregard both AFCS GIPs and War Pensions, demonstrating that the Government recognises that neither should be viewed as 'income'."[32]

Currently there are 85,205 War Disablement Pensioners throughout England, of whom only a minority face social care costs. We also know that to address this unfair anomaly a number of councils have chosen to disregard the WDP in the social care financial means test.

We believe funding should be made available to allow all councils to exempt the WDP from the means test and ensure that all injured veterans are treated equally. This would signal the government's continued commitment to the Armed Forces Covenant.

Asylum seekers

The Prime Minister has recently announced that people who have been refused asylum seeker status or who are asylum over-stayers will not be entitled to benefits. According to case law, local authorities are responsible for those who have no other means of support and that will include social care services where appropriate, creating additional pressures on council budgets which should be funded alongside all of those listed above.

32 Submission to, 'Caring for our future: consultation on reforming what and how people pay for their care and support', Royal British Legion, October 2013

What if adult social care continues to be underfunded?

The evidence set out above shows that adult social care is now under enormous pressure. Moreover, it shows that the ability of councils to mitigate the impacts of the pressure is not sustainable. So what might happen to the service if, in funding terms, the next five years mirror the experience of the previous five?

Local authorities will always balance their books, but in the process services and the people who need them will be affected. Many councils have nearly reached the point where efficiencies have run out across all their services and are therefore now reducing their availability. The scale of the savings needed is very daunting. To put the annual £700 million funding gap facing adult social care in context, total spend on children's centres across England amounts to about £750 million per annum.

The savings challenge does not include the effect of some serious structural weaknesses in the provision of care services, as outlined in the provider and workforce sections above. 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 and the delivery of sufficient quality to maintain people's dignity and not cause harm.

The situation is as demanding in residential care. Many providers are at marginal viability and others are only able to accept local authority price rates by cross subsidising from paying clients to local authority ones.

Some providers may withdraw from the public sector market to concentrate on services to self-funders. The likelihood is that costs will have to rise more than planned if failure in supply is to be avoided.

In practice adult social care will be required to make more savings. Some efficiencies can still be made in some places by further reduction in direct provision, an increase in direct payments, increased use of technology and re-enablement strategies. But there are serious limits to their effectiveness. Additionally, the Care Act puts prevention, carers, safeguarding, wellbeing and information and advice services on a statutory footing.

Under the Care Act all councils now provide eligible care and support only to people with levels of need broadly equivalent to the previous 'substantial' Fair Access to Care threshold. There is no formal way of reducing the scale of the offer, in itself not an aspiration but perhaps a necessity for councils given the funding challenge.

What happens when all avenues have been exhausted? A variety of adaptive behaviours are emerging, often without conscious design. For example, waiting times for assessments (including for carers) may increase, care packages may be trimmed, quality and safety may be reduced, and there may be other delays in implementation as different approaches to rationing the limited service.

How will it become apparent that the service is failing?

Already the Care Quality Commission is reporting that 8 per cent of regulated services inspected under the new regime are inadequate and 34 per cent require improvement. Over 20 per cent of nursing homes failed to meet essential standards of safety and safeguarding in 2013/14. A proportion of providers are leaving the market or restricting supply to people who pay for their own care.

While unlikely, there could be a dramatic collapse in supply due to financial failure (or as a precursor to it due to enforcement or safeguarding actions), which might be either local (if small localised supplies fail) or national if a major provider collapses. This may require public intervention to correct, if large enough, or it will drive up prices and create overspends that reinforce the rationing process.

This is not just about supply failure though. It is well evidenced that moving home for people with complex needs increases mortality unless well planned. Even a single small home closing without notice causes significant distress to those concerned.

In some places there may be successful judicial reviews of care assessments, particularly with respect to services to disabled people. Should the courts have to take a view, previous experience suggests they are likely not merely to restore previous levels of care but move the boundary further towards more generous support for. This will have significant impacts on all local authorities, not just those under scrutiny.

Finally, there will be a growing risk of a scandalous tragedy, which illustrates the growing risk in the sector while also reflecting poorly on the individual authority. It would be complacent indeed if the national response to such individual failure was to focus just on the management and leadership in that one place.

As social care services come under such increasing pressure, so too will the NHS, as there is less and less capability of maintaining people in their own homes. One approach might be to continue to, by default, expand the acute NHS expenditure whilst allowing primary, community and adult social care to deteriorate, but that would be short sighted and irrational.

The funding situations in both the NHS and adult social care are permanently interconnected. There are examples of effective substitution, for example, in relation to extra care housing or Shared Lives schemes. Investment and protection of adult social care would come at a small cost measured in terms of the NHS budget but are a fundamental and logical way of mitigating growth in demand for medical and nursing care services.

Taking integration further

KEY POINTS

Integration of social care and health is the right approach, particularly for improving outcomes for citizens, but also because it appears to be the best chance of improving value for money in the long term.

A transformation fund, worth £2 billion in each year of the Spending Review period and controlled by health and wellbeing boards (HWB), would support the service transformation needed to make the integration of social care and health a reality, with part of the funding supporting investment in a more ambitious prevention strategy, with an estimated net rate of return of 90 per cent.

With the funding gap closed and the transformation fund in place, the BCF should be expanded with both 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. Lessons from what has worked well and what hasn't should underpin its evolution.

However, integration cannot progress if social care services remain underfunded as this would jeopardise local relationships and initiatives. Meeting the funding gap must be the first priority.

Financial pressure and the need for better quality make the working relationship between the NHS and local government more important than ever. For local government, working together to bring about real change is essential, not just desirable. A failure to collaborate will only exacerbate existing pressures and fragment the system further.

The benefits of adult social care's contribution to an integrated system accrue to both individuals and the NHS. For the former the service provides an increasingly personalised response that is geared towards promoting independence and inclusion, safeguarding people's rights, delaying or avoiding the onset of more difficult and costly conditions.

For the latter the service helps alleviate demand pressures, allowing a focus on priority patients. The relationship is reciprocal, of course; NHS and clinical practice helps to delay the need for long-term care and support.

The future system must play to these respective strengths; an NHS whose strengths include diagnosis and emergency care, and a care system that is equally strong on personalisation and prevention. But if we are to realise the aspiration of an overall system that helps support a national population that is healthier, more independent, out of hospital, and pursuing their ambitions in their communities, then we must go further.

Transformation and prevention

Speaking at the LGA annual conference in July 2015 the Secretary of State for Health said:

"Some of the [BCF] plans we're seeing are truly transformational. Seventy five per cent of the pooled budgets are being ploughed not into NHS acute care, but into social and community care – exactly the shift we need to keep people healthy and happy in their own communities, to prevent rather than cure, and to avoid unnecessary hospital admissions."

It is encouraging that Government recognises the need to focus on prevention. But that simply will not be possible without new investment. Indeed, the ADASS Budget Survey shows that adult social care spending on prevention has actually decreased by 6 per cent this year.

The LGA and ADASS have consistently argued that there is a need 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 can be realised.

A transformation fund, worth £2 billion each year over the Spending Review period and delivered upfront and in part for new local prevention services, could prevent problems arising in the first place, prevent dependency on the social care and health system, or – when targeted at the right groups of people – prevent the escalation of problems which become worse for individuals and more costly to the taxpayer.

Locally, councils work with a range of partners to take preventative work forward, but nothing has really been done previously at scale. We believe that local areas – supported by strong local governance and risk management – are well placed to deliver the more ambitious degree of change that is needed.

For this reason the LGA has conducted research on a range of local prevention schemes to better understand the level of financial savings that can accrue from them. This has led to the development of a Prevention Spending Model (PSM) that looks at what return on investment might look like if individual projects were scaled up nationally.

The different schemes are delivered by a range of providers covering councils, the NHS, and voluntary organisations. Schemes were only included in the PSM if they were delivered in part or in full by a council and if the return on investment was achieved within a five year period. For further detail on the methodology of the PSM see the Appendix.

Key findings from the 11 projects that constitute the PSM work are as follows:

- total cost of implementing all 11 projects nationally: £17 billion
- expanding combined 11 projects through a prevention strategy could yield a return of 90 per cent
- the cost benefit ratio varies between projects but can be as much as £20 per £1 spent (including non-cash benefits)
- a further £2 billion of savings were also identified. These are not included in the net savings as they are benefits relating to children and young people.

Other considerations in relation to transformation funding for prevention are set out below.

- Local areas are best placed to make decisions about how to transform local services. Therefore, consideration should be given to the merits of combining all government transformation funding into a single grant scheme that local government could have decision-making powers over. This would mean a far simpler and streamlined process and would ensure that transformation was led locally, based on local knowledge of priority areas.
- Consideration should be given to how capital funds might most usefully be used. Notwithstanding the need for revenue funding to support the capital asset, there could be benefits in the use of capital funding to support technological improvements and some large-scale developments, such as extra-care housing.
- It would be helpful to consider a model in which councils are able to borrow more to pump-prime prevention, with a proportion of savings being passed back to the Treasury. In this way Government would act as the vehicle by which savings are realised thus bypassing complex contracts between councils, hospitals and third parties.

Public health

This year, local authority public health services will have to absorb an unplanned in-year reduction of £200 million, more than 6 per cent of the total budget.

We are extremely concerned that these in-year reductions may undermine the objectives we all share to improve the public's health and keep pressure of the NHS. Moreover, the Government's rationale for the reductions appears flawed. We understand that the Treasury has based the £200 million reduction on projected council underspends reported in 2013/14 and consequently believes that the reduction will not impact on frontline services.

In most cases these are not underspends at all; rather they are planned approaches to spending on public health services developed over multiple years. Indeed, the ringfenced budget and multi-year funding allocations were designed to incentivise such an approach. As a result, the reduction in public health funding means that these longer term delivery plans have to be changes in-year at short notice.

For many councils the largest proportion of the public health budget is used to commission NHS services, such as sexual health, public health nursing, drug and alcohol treatment, and NHS health checks. Councils will have little or no choice to passport the reductions on to all providers and the NHS will therefore not be immune to the impact.

It is also worth noting that councils contributed an additional £56 million to public health over and above the ringfenced budget from other council services (such as housing and leisure, for example). One potential impact of the in-year reductions is that it may therefore act as a deterrent to contributing resources from other funding streams in the future.

A bigger BCF

Despite serious concerns about the process, the introduction of the BCF has marked an important change in how care and health interact within a place, with residents being placed at the heart of the change.

The fact that the nationally mandated £3.8 billion BCF was increased by an additional £1.5 billion from local care and health budgets demonstrates that local areas are ambitious and ready to lead further integration, backed by clear and strong budget accountability. Expected savings to the NHS and councils are estimated at £500 million this year alone – almost 10 per cent of the upfront investment. The next iteration of the BCF could be the vehicle for going further, particularly if it facilitates local engagement in transformation

and a focus on improving outcomes. The Greater Manchester devolution deal pooling local social care and CCG budgets from April 2016 further illustrates the direction of travel.

We propose an expansion with both 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. Lessons from what has worked well to date and what hasn't should underpin its evolution. Analysis by Ernst & Young shows that if all spending on long-term conditions was pooled in this way, the expanded pool would be worth £88 billion. Even a 4 per cent saving on this – in comparison to the 10 per cent forecast for the current iteration of BCF – would result in further significant savings which could be reinvested, up to £3 billion in a steady state.

Despite its future potential and progress to date, the experience of the BCF so far has highlighted the risks involved in the process, which can also vary from place to place. With both systems under financial pressure, we are already seeing difficult local discussions in some areas which put existing agreed arrangements under strain. Therefore, if the national aspiration is to accelerate integration then social care and health need to be more balanced. This is true in funding terms (as highlighted above) but also in terms of overall standing.

Tension is created when the NHS makes decisions without reference to local government and this can undermine local partnership working. The decision – driven by NHS concerns – to change the terms of the BCF to restrict the objective to just reducing unplanned hospital admissions in the middle of local planning BCF plans is a clear case in point.

This decision made delivering the plans more difficult and left many councils with significantly less time to plan. It also undermined the core purpose of promoting locally-led, integrated care (and as a consequence made the process more competitive than collaborative). For integration to truly succeed social care and health must be seen as equal partners, with Government demonstrating commitment to this principle from the very top.

Our starting position for a 'next steps' BCF is therefore that the overall resource for adult social care must not be left worse off as a result. This may happen if a future BCF involved a simplification of various funding elements and a return to straightforward Section 256 transfers, which is one feasible option for the future. For this reason we believe there is an order of priority for integration.

Closing the gap in social care funding must be the immediate and shared top priority to ensure the sustainability of the system itself in terms of accessible, quality services and provider viability. Transformation funding for prevention is a next level priority; there is little point (and indeed little chance) of securing meaningful transformation to preventative models of care without initial pump-priming to allow for some double-running of new investment and 'business as usual'.

If neither of these two priorities are addressed the Government may still wish to pursue the expanded BCF approach. Should this happen a number of national barriers will need to be addressed. These include:

- the need to develop integrated data sets and information systems
- development of organisational cultures and workforce to support joint working
- alignment of technology, financial systems, benefits and risks
- the need for a single outcomes framework across health, public health and adult social care
- aligning incentives
- long term financial settlements and planning
- strengthening governance arrangements at HWB level
- the role of regulators and performance management – if the aspiration is to integrate social care and health there should be an accompanying aspiration for a single and simpler regulatory framework.

A ‘next phase’ BCF should address these barriers and set up the right incentives for local and national systems to move towards our vision of more fully integrated social care and health services in order to improve outcomes. However, an expanded BCF (without funding for social care or transformation) would also need to be developed with clear conditions, including:

- a much clearer and more transparent mechanism for ensuring money gets directly through to social care
- much less central bureaucracy and performance management
- greater local management of the fund and much more local determination of its use
- a much greater emphasis on prevention and early intervention
- a much greater emphasis on early joint planning to manage winter and seasonal pressures and less emphasis on A&E admissions and delayed transfers (in essence a further argument for greater preventative work).

Conclusion

We share the Government's vision of a social care and health system that delivers better, safer, more coordinated and more personalised care for people. We are all responsible for changing attitudes towards the service – whether that is amongst the public, the media, the NHS or politicians. However, there is still much to be done to achieve the kind of system we are committed to.

We stand ready to go further with integration of social care and health services if the conditions are right. The experience to date has inevitably made some within the sector cautious, but it has also made plenty more cautiously optimistic. We have an important opportunity to create the right conditions for local areas to drive a greater scale and pace of integration and local government will be a willing partner in co-designing them.

The November Spending Review is a crucial opportunity for the Government to begin this process. In its decision to delay the implementation of Phase 2 of the Care Act the Government has recognised the risk of undertaking major reform on a shaky foundation. The same logic applies to wider integration efforts. Regardless of best intentions of local government, there is a real risk of this important reform failing if both partners are not funded properly.

Adult social care is facing very real and serious funding pressures, the impact of which will ultimately fall on the people who require our services. The funding gap must therefore be closed and the money from the delayed Phase 2 Care Act reforms should be used for this purpose. This will not be sufficient to meet the predicted gap over the next Spending Review period so new money must be found for the remainder.

However, 'plugging the gap' must not be the extent of our aspiration. If we are to really transform our care and health system then the Government should invest substantially in prevention, and trust local areas to build on their excellent track record of smaller scale preventative activities and scale them up. This makes sense for people, for social care, and for the health services.

Appendix. Prevention spending model (PSM)

Methodology and explanation

The LGA has created a prevention spending model (PSM) that looks at how much money could be saved if authorities were able to invest in activities that improve health outcomes.

In order to achieve this, the LGA reviewed an extensive range of intervention case studies that had provided a cost benefit. There were two types of case study. The first were models developed to explore potential savings that an intervention could in theory generate, generally used to rationalise the implementation of a prevention project. The second were evaluations of interventions that had been undertaken in a real-life setting (intervention evaluations). For the purposes of our model all, except one, of the case studies included were intervention evaluations. Intervention evaluations were selected over models to ensure that the cost benefits associated with the intervention were grounded in real experience. The only model included was written by the National Institute of Clinical Excellence in Care and health (NICE).

Whilst intervention evaluations were used, the cost benefit element was sometimes based on a model. The models used by case studies included in the PSM varied, but had generally been devised by respected agencies and organisations such as the Department for Communities and Local Government (DCLG), Matrix Insight (commissioned by Health England) and the Chartered Institute of Environmental Health (CIEH).

The case studies reviewed were delivered by a range of service providers, from local authorities and the NHS to voluntary organisations and charities. Case studies were only included if they were delivered in part or in full by a local authority. That said, the resulting cost benefits are delivered to a wider audience, including to the NHS and the Department for Work and Pension. All of the interventions are of benefit to the individual, whether it is improved mental and physical health, or quality of life, however these benefits are not included within the model unless they have been monetarised or have a cost impact on the provision of a service.

The case studies included in the PSM had varying time frames. Some required a single year of investment, but generated cost savings for up to five years; others were, for example, a two year intervention which delivered cost benefits within the same time frame. Because of the underlying calculations used by each of the models, it was not possible to present the case studies within a single timeframe; however, time frames are included against each case study within the model.

Case studies that were for a single authority area were scaled to estimate the costs and savings at a national level. Case studies that looked at prevention spending for a proportion of the population (for example, the Matrix reviews) were applied to national population figures.

Whilst the case studies were scaled to a national level, it does not imply that projects reach all of the target populations. For example, one service worked to upgrade housing that was found not to be decent, the authority assisted 19,342 households, but they identified an additional 45,000 that would also benefit from the scheme (Birmingham Decent Homes), therefore, when applied to a national level, the programme would, in theory assist around 19,000 households in each authority area, but not all households that would benefit.

Explanation of the cost benefit ratio

The PSM identified 11 case studies, delivered in full or in part by local authorities, which demonstrated that an investment in activities to prevent ill-health or improve health outcomes can deliver savings (either to local authorities or to other sectors).

If the project costs and the savings of the 11 prevention case studies are summed they create a net return of 90 per cent, that is, a cashable saving of £1.90 for every £1 invested.

Each case study, however, has its own cost benefit ratio: for example, one intervention has a return of £20.69 per £1 invested (BeActive Birmingham), whilst another has a return of £0.003 per £1 invested (Carers with Depression). Table 1 below shows the cost benefit per case study.

All case studies have been included, even if they have a low return, this is because the model is outcome focused, rather than output focused and considers the differences actions and activities can make in people's lives.

Table 1: Cost benefit ratio by intervention

Name of intervention	Cost benefit (per £1)	Intervention Area
BeActive: 40-65 year olds	£20.69	Health
Glasgow Health Walks	£7.90	Physical and mental health
Incredible Years Programme: Adult Benefits	£3.12	Parental depression
Telehealth Care	£2.68	Independent living for people with learning difficulties
Link Age Plus: 50+ Employment	£1.95	Employment 50+
NICE: Tobacco Harm Reduction	£1.46	Reduction in smoking
POPP: Partnership for Older People Projects	£1.20	Older people: saving in emergency bed days and additional service benefit from addressing older people's presenting needs
Handyman	£1.13	Independent living for older, disabled and vulnerable people
Decent / Warmer Homes	£0.98	Housing
Kent Supported Employment	£0.49	Employment: mental and physical
Matrix: Carer Depression	£0.003*	Carers

* This only includes the savings made in prescriptions and does not quantify the savings made from carers being able to continue caring.

The selection of prevention projects would vary in each authority area depending on the local context and needs, and existing services. Therefore, the cost benefit ratio would also vary.

Table 2 below shows, for illustrative purposes only, how £1 billion could be spent across the 11 projects to generate benefits of £7.19 billion and savings of £1.9 billion – a net return of 90 per cent. If each project were implemented nationally the 11 interventions would require an investment of around £17 billion, with potential savings of £99 billion.

Table 2: Potential cost benefits of a £1bn national Prevention Transformation Fund

Intervention Area	Intervention spend in £000s	Benefits in £000s	Cashable savings in £000s
Glasgow Health Walks	1,000	7,897	7,000
NICE: Tobacco harm reduction	50,000	73,000	73,000
Handyman	19,000	21,508	19,704
POPP: Partnership for Older People Projects	200,000	240,000	240,000
Link Age Plus: 50+ Employment	50,000	97,462	97,462
Telehealth Care	20,000	53,564	53,564
Matrix: Carer depression	100,000	270	270
Incredible Years Programme: Adult benefits	108,000	337,074	337,074
BeActive: 40-65 year olds.	300,000	6,207,273	930,000
Decent / Warmer homes	150,000	146,833	146,833
Kent Supported Employment	2,000	980	980
Combined costs	**1,000,000**	**7,185,861**	**1,905,887**

Local Government Association
Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

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