SIGOMA

SIGOMA RESPONSE TO

THE JOINT SELECT COMMITTEE INQUIRY INTO THE LONG-TERM FUNDING OF ADULT SOCIAL CARE

The Special Interest Group of Municipal Authorities (Outside London)

SIGOMA Response to the Social Care Green Paper Inquiry

1.0 About SIGOMA

1.1 SIGOMA is a special interest group of 46 English councils, including 33 metropolitan boroughs and 13 unitary authorities.

1.2 Our membership comprises authorities in the North East, Yorkshire and the Humber, the North West, Midlands and the Southern Ports.[1]

1.3 Social Care represents the main single area of spending for all single and upper-tier authorities. SIGOMA represents 30% of the 155 authorities responsible for care provision in England.[2]

1.4 Of the 10 most deprived authorities in the country for health deprivation and disability, 7 are SIGOMA members.[3] There is a strong correlation between deprivation and care costs, placing much higher than average pressures on our authorities.

2.0 Summary

2.1 Government must urgently expand the scope of its green paper to properly consider the care of children and younger adults.[4]

2.2 Long-term sustainability cannot be achieved without first addressing the £4.3bn funding gap for care services councils face by 2020.[5]

2.3 A significant increase in funding is also needed to remedy the impact of austerity to-date and enable councils to keep pace with the demands of a rapidly ageing population.

2.4 The unbalanced pressures on different councils, which are currently resulting in an untenable postcode-lottery of services, must also be addressed. To do so, Government must ensure all social care funding is formula-based and needs-driven.

2.5 The social care market is held up by the cross-subsidisation of council-funded places by self-funders. This is warping the quality of local provision and sustainability of staffing. Councils must therefore be sufficiently funded to meet their statutory responsibility to have a market shaping influence over local provision[6] and foster a sustainable workforce.[7]

2.6 Uncertainty surrounding future care funding limits councils' capacity to undertake invest-to-save initiatives and negotiate more cost-effective long-term contracts, as well as affecting providers' willingness to invest. Providing long-term certainty will therefore be crucial.

2.10 Recent Conservative manifesto pledges taken at face value would appear to increase the financial responsibility of authorities for care services and, with it, pressures on local budgets.[8] Should Government proceed with these measures, they must ensure any additional pressures on councils are fully funded.

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[1] www.sigoma.gov.uk/members
[2] ADASS., Budget Survey 2016, p4 - 30% in number of the 155 local authorities in England with adult social care responsibility in England
[3] DCLG., English Indices of Deprivation 2015, upper-tier local authority summaries, health deprivation and disability rank of average score
[4] House of Commons Library (Jan 2018)., Social care: the forthcoming Green Paper on older people (England), p4 "[Government] hasn't made a commitment to publish a social care Green Paper for working-age adults."
[5] LGA., (Autumn 2017) Budget Submission, p7
[6] Care Act 2014 p5
[7] Ibid.
[8] The Conservative and Unionist Party Manifesto 2017, p65

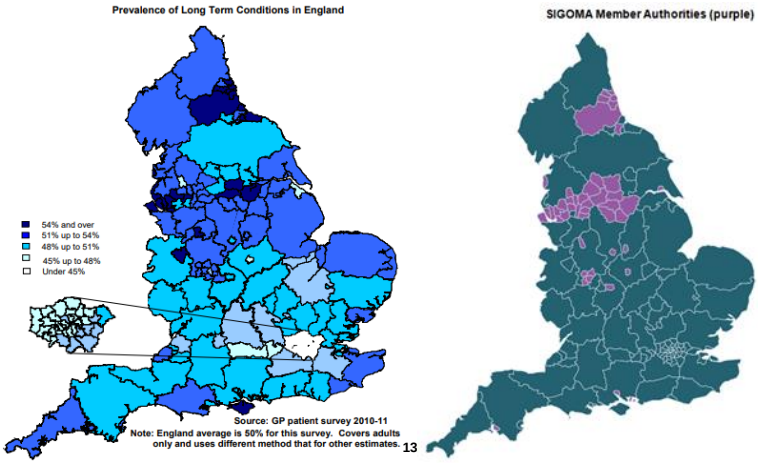
3.0 Scope

3.1 Government has committed to putting forward a green paper to secure the "long-term sustainability of both the health and care systems" but has also indicated that it will focus principally on "older people".[9]

3.2 The absence of care for younger adults with mental health conditions, learning and physical *disabilities or children's care from its scope therefore appears a notable oversight.*

3.3 These areas are of particular concern to local authorities as the former amounts to over half of spend on Adult Social Care and the latter represents the greatest single area of spend for many councils.[10]

*3.4 According to the LGA, "*Councils were planning to spend approximately £1 billion more on… care services to working age adults than to older people in 2017/18."[11] In deprived areas where manual workers make up a greater relative proportion of the workforce, occupation related long-term conditions can increase the number of residents that present within this age group.[12]



3.4 According to a recent study by the universities of Huddersfield and Sheffield too; "Adjusted for inflation… overall spending on children's services has fallen by 16% across England". But "in the poorest areas the figure is 27%, compared with 4% in the wealthiest."[14]

3.5 Given, in particular, the greater relative pressures these components of care provision hold for SIGOMA members, it is crucial they are given equal attention.

3.6 While the former First Secretary had indicated that care for younger adults *would* be reviewed by "a parallel programme of work", no further announcements on this appear to have been made and no timeline given.[15]

3.7 And, while MHCLG and DfE have commissioned research into the cost drivers of children's services in connection with the Fair Funding Review, there has been no indication

[9] Joint inquiry on long-term funding of adult social care
[10] House of Commons Library (Jan 2018)., Social care: the forthcoming Green Paper on older people (England), p10
[11] LGA (Autumn 2017)., Budget Submission, p5
[12] Cllr. Kieran Quinn (Tameside) "We have an unhealthy population, not just because of a higher percentage of smoking and exercise issues. It is linked to earlier employment [and] heavy manual work." Financial Times (April 2017)., National living wage rise heaps care costs pressure on councils and "in London and South East… there is a much higher proportion of workers in low-risk occupations than across the rest of England" Health and Safety Executive., County and Regional Statistics
[13] Department of Health (2012)., Long Term Conditions Compendium of Information, Third Edition p9
[14] Alison Holt (Feb 2018)., Poorest areas face biggest cuts to children's services, BBC News
[15] House of Commons Library (Jan 2018)., Social care: the forthcoming Green Paper on older people (England), p4

that this will be extended to cover the issues to be considered in this paper, of how future costs will be funded.

3.8 Government should broaden the scope of its green paper to include long-term solutions for younger adults' and children's care, ensuring the consultation undertaken following the launch of this green paper results in a timely solution for all elements social care provision.

Q1) How to fund social care sustainably for the long-term (beyond 2020), bearing in mind in particular the interdependence of the health and social care systems?

4.0 Existing funding gap

4.1 While the question specifically refers to funding solutions post-2020, future sustainability cannot be divorced from present funding concerns.

4.2 Funding has failed to keep pace with demand and, according to the LGA, councils face an overall social care funding gap of £4.3bn by the end of the decade.[16]

4.3 Cost pressures have also been faced following increases to the national living wage, which have had a more damaging impact in some parts of the country than others according to differing local pay-spines (with many SIGOMA authorities particularly hard-hit),[17] and a recent ruling regarding the remuneration of sleep-in-carers.[18]

4.4 Sustainability also depends on having sufficient resources not only for day-to-day costs, but also prevention. But, according to the Joseph Roundtree Foundation: "Long-term, preventative approaches are [now] being compromised by the need to make short-term savings,"[19] and this is borne out by council budget data.[20]

4.6 This imposed short-termism has damaged the sustainability of the sector. According to the Competition and Markets Authority; "Looked at as a whole, the [care] sector is just able to cover its operating costs and cover its cost of capital. However, this is not the case for those providers that are primarily serving state-funded residents."[21]

4.7 Any unmet care demand can also result in complications for patients, increasing their likelihood of requiring greater support in the future. The ongoing pursuit of short-term savings may therefore be storing up even more long-term costs for the future.

4.8 Government must close the funding gap for adult social care services first in order to shore-up the foundations on which a more sustainable system can be built.

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[16] This includes a £1.3bn existing social care funding gap and an additional £1bn funding gap in adult social care alone by 2020 LGA (Autumn 2017)., Budget Submission, p5

[17] "43% of English care workers… aged 25 and over earn less than the national living wage". But, for some SIGOMA authorities, this can rise to around three quarters, resulting in an unbalanced relative pressure Financial Times (April 2017)., National living wage rise heaps care costs pressure on councils

[18] "The cost could amount to £400 million for backdating pay and up to £200 million a year in ongoing annual salary costs." LGA (Autumn 2017)., Budget Submission, p5

[19] Joseph Roundtree Foundation., The Cost Of the Cuts: the Impact on Local Government and Poorer Communities p5

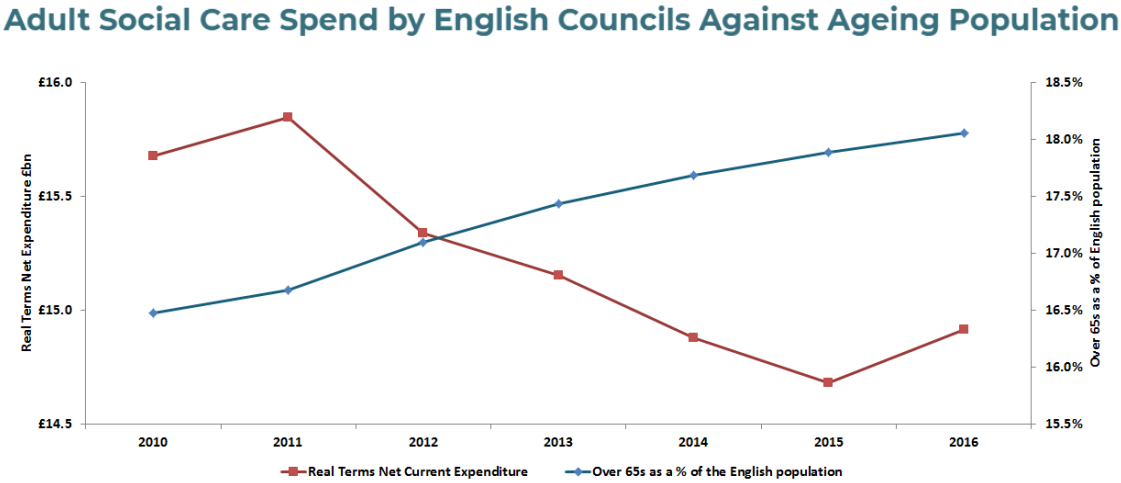
[20] While social care spending in England saw a sub-inflation cash terms increase of 0.17% between 2014 and 2017, this included a 13.1% cut to spending on 'Information and Early Intervention'. Based on SIGOMA analysis of Revenue Outturn Data

[21] Competition and Markets Authority (Nov 2017)., Care homes market study: summary of final report

4.9 They should work closely with councils to understand the true cost of delivering care services, ensuring the full costs (including those of invest-to-save initiatives) are met in full.

5.0 Ageing population and wider service cuts

5.1 Between 2010 and 2016, English councils were forced to reduce real terms spending on adult care by 5%, despite a 1.7% increase in over 65s as a proportion of the English population over the same period.[22]



5.2 And, according to ONS projections, between 2014 and 2039, the pensionable aged population will have increased at almost 3 times the rate of the working age population.[23]

5.3 This pressure is not spread evenly. Most notably, a long standing brain-drain towards the capital[24] has resulted in significant variation in over 65s as a proportion of council populations.

5.4 While most regions containing SIGOMA members[25] trend close to the national average (18% in 2018), London has a very low relative elderly population (with over 65s making up just 12% of the region's projected population in the same year).[26]

5.5 This imbalance has a significant impact on relative care costs. Just 14% of those aged under 40 report a long-term condition, but this rises to 58% for over 60s.[27] Costs associated with the 'middle old' (75-85) and 'oldest old' (85+)[28] are even greater, with residents within these age ranges presenting much higher levels of multi-morbidity.[29]

5.6 Though finding more efficient ways of working will continue to be part of the solution, Government must therefore find significant and increasing additional resources to ensure care continues to be funded sustainably and according to local needs profiles.

6.0 Unbalanced austerity

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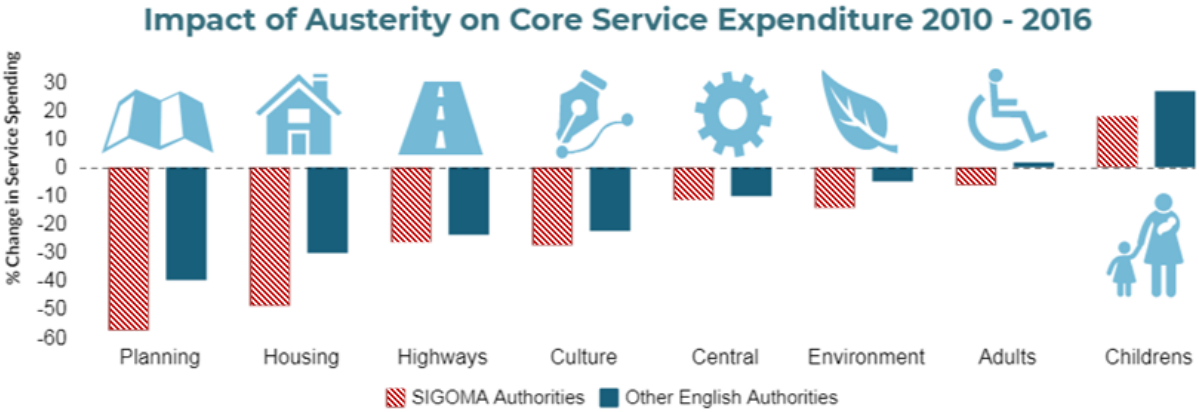
[22] House of Commons Library (Oct 2017)., Adult Social Care Funding (England) p11
[23] Office For National Statistics (Oct 2015)., National Population Projections: 2014-based Statistical Bulletin, Table 4
[24] Centre for Cities., The Great British Brain Drain: Where graduates move and why
[25] 17% in 2018
[26] Office For National Statistics (Oct 2017).,Principal projection for the UK including population by broad age group, 2014 based population projections
[27] Department of Health (2012)., Long Term Conditions Compendium of Information, Third Edition p7
[28] Suzman R, Riley MW (1985)., Introducing the 'oldest old.'. Milbank Mem Fund
[29] Andrew Kingston, Louise Robinson, Heather Booth, Martin Knapp and Carol Jagger (Jan 2018)., Projections of multi-morbidity in the older population in England to 2035, British Geriatrics Society, Table 2

6.1 Real-terms cuts to council spending on adult social care have occurred despite this service being protected more than almost any other – the exception being children's care.

6.2 Since social care forms only the most visible tip of the iceberg of wider austerity, the relative protection of care budgets cannot be viewed in isolation from cuts to other services.[30] These pressures have fallen disproportionately on SIGOMA authorities.



6.3 While other English councils have been able to increase adult social care budgets by 1.7% in cash-terms between 2010 and 2016, SIGOMA councils have been forced to cut spending by 6.4%, despite affording it equal priority status.

6.4 This relative protection of the service has occurred despite a 41% cut to adult social care funding as a share of Revenue Support Grant (councils' main source of central government funding) from £12.6bn in 2013-14 to £7.5bn in 2017-18.[31]

6.5 It is reflective too of the overall reduction to SIGOMA authorities' core spending power of 27.4%, compared to the English average of 19.5% this decade.

6.6 Austerity has also been accompanied by funding decisions that have tended to favour more affluent authorities, namely a damping adjustment built into the local government funding formula since 2013-14[32] and Transition Grant.[33]

6.7 A sustainable solution must therefore be sensitive to the impact of austerity and departmental funding decisions to date, which have impacted councils' ability to protect care budgets to differing degrees.

6.8 It must also be implemented as soon as possible with minimal transition, in order to ensure all councils are funded more sustainably, according to need, at the earliest opportunity.

7.0 Higher pressures

7.1 As mentioned above, 7 of the 10 most deprived councils in the country in terms of health deprivation and disability are SIGOMA authorities and 96% of our members are more deprived than the English average.[34]

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[30] Patrick Butler (Feb 2018)., Tory county council runs out of cash to meet obligations, The Guardian

[31] In 2013-14, the service level allocations of RSG were frozen. At that time, the Adult Social Care element of this funding made up 39% of its total value. Since then, cuts have been applied to total RSG, meaning the Adult Social Care element would decrease proportionally and allowing us to postulate a current notional value.

[32] DCLG (2011)., Methodology for Floor Damping in the 2013-14 Local Government Finance Settlement

[33] National Audit Office (Feb 2017)., Transition grant and rural services delivery grant

[34] DCLG., English Indices of Deprivation 2015, upper-tier local authority summaries, health deprivation and disability average score; and deprivation average score

7.2 According to Department of Health data, residents in the most deprived quintile of areas were 60% more likely to suffer from a long-term condition and suffered, on average, 30% more severe long-term care needs.[35]

7.3 Deprivation also limits healthy life expectancy. The average life expectancy is shorter for SIGOMA residents and more of it is lived in ill health – 11 years in SIGOMA authorities compared to a national average of 9.[36]

7.6 According to Paul Carey-Kent of CIPFA,[37] councils have endeavoured to limit care costs by "interpreting [the eligibility criteria for care services] more tightly or trying to imaginatively divert people to other services."[38]

7.7 The disproportionate burdens and demand faced by SIGOMA authorities are likely to have increased pressures upon them to explore such avenues at a disproportionate rate.

7.8 This view is supported by the findings of the 2016 English Health Survey, that residents in the most deprived areas were around twice as likely to have unmet need for at least one activity of daily living than residents in the least deprived areas.[39]

7.9 Such imbalances undermine fairness and sustainability. Government must therefore make additional funding available to address this unmet need, ensuring its allocation is strongly correlated to deprivation.

7.10 Adult Social Care driven needs will likely be incorporated into the new local government finance formula, currently under consideration as part of the fair funding review.[40] The social care green paper must therefore consider the interaction and integration of its proposals with this formula to ensure the two work streams are mutually reinforcing.

8.0 Lower revenue raising capacity

8.1 Despite these unbalanced pressures, Government has made councils increasingly reliant on their local tax bases to fund vital services.[41]

8.2 Following years of austerity, this trend is leaving them with little choice but to pass the growing cost of care services directly to local residents (with 95% increasing council tax in 2018).[42] However, very different amounts of tax can be raised in different areas.[43]

8.3 In 2016, for example, SIGOMA authorities were able to raise less council tax per head than any other upper-tier council group, just £332 per head, compared to £344 in London boroughs and £468 for counties.[44]

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[35] Department of Health (2012)., Long Term Conditions Compendium of Information, Third Edition p11

[36] SIGOMA analysis of Office for National Statistics (March 2016)., Healthy life expectancy (HLE) and life expectancy (LE) at age 65 by upper tier local authority (UTLA), England

[37] The Chartered Institute of Public Finance and Accountancy

[38] Financial Times (April 2017)., National living wage rise heaps care costs pressure on councils

[39] NHS Digital/ONS., (Dec 2017) Health Survey for England 2016: Social care for older adults p1 (Deprived: men 33% and women 42%, Affluent: men 15% and women 22%)

[40] MHCLG (Dec 2017)., Fair funding review: a review of relative needs and resources

[41] This can be seen in the Adult Social Care Precept (up to 6% total over 3 years), introduced in the 2016-17 Local Government Settlement, as well as additional Council Tax Flexibility (1%) and the Mayoral Levy (discretionary and technically uncapped), announced at the 2018-19 Local Government Settlement. When considered in addition to the 1.99% flexibility councils have been able to levy historically, this amounts to a potential increase of more than 13% over the last three years, which MHCLG assumes will be used in full within its core spending power figures.

[42] LGiU/MJ (2018)., State of Local Government Finance Survey

[43] According to the strength of local tax bases Jo Miller (Jan 2018)., Council tax is a regressive tax - it's time to do something, The Municipal Journal

8.4 This demonstrates that council tax increases cannot be used to fund care fairly or sustainably, and the same is true of business rates.

8.5 Government policy continues to encourage greater reliance on business rates revenue to fund services – with MHCLG aiming for 75% retention by 2020-21.[45]

8.6 However, in 2016 SIGOMA authorities raised just £177 per head in business rates compared to £181 per head for counties and £260 in London boroughs.[46]

8.7 While some grants, such as the Additional Better Care Fund, have compensated for variations in tax raising ability, this has not been true of all social care funding and, when applied, has not taken into account all additional tax raising ability through, for example, the 1% general increase in council tax flexibility announced for 2018-19.[47]

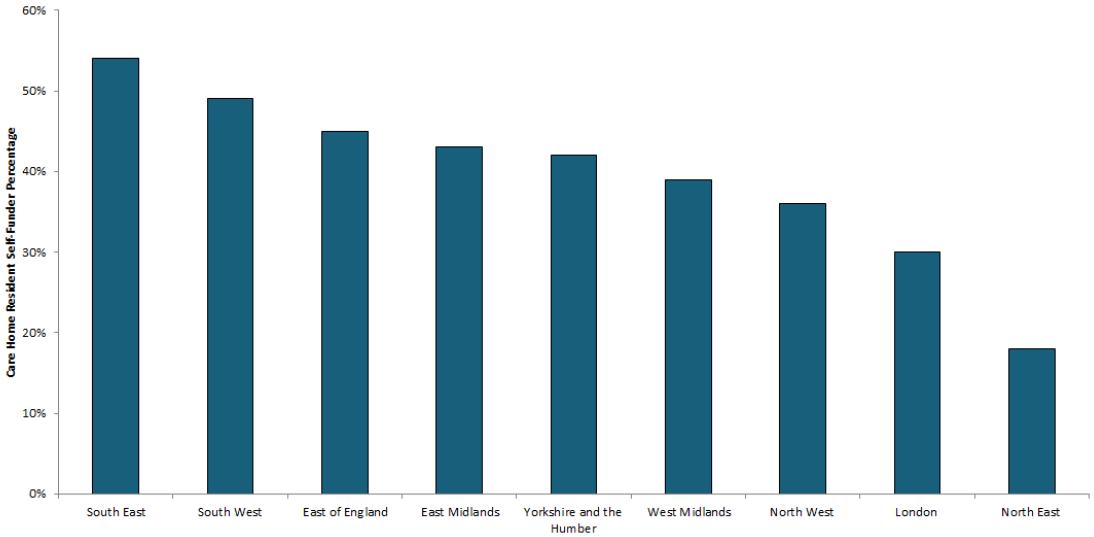
8.8 Allocation methods based on the strength of local tax bases have meant deprived areas have been able to raise much less for social care services than their neighbours, despite facing higher than average demand. This is not sustainable.

8.9 Central government must fund councils according to their relative needs, taking into account relative local resources.

9.0 Self-funding markets and care home rates

9.1 According to the National Audit Office: "around 65% of [care] providers' income comes from… local authorities, so public funding is essential to the sustainability of the sector."[48]

9.2 But, according to Laing Buisson,[49] the ratios of self-funded to council funded residents vary significantly from one region to the next, as shown below.[50]

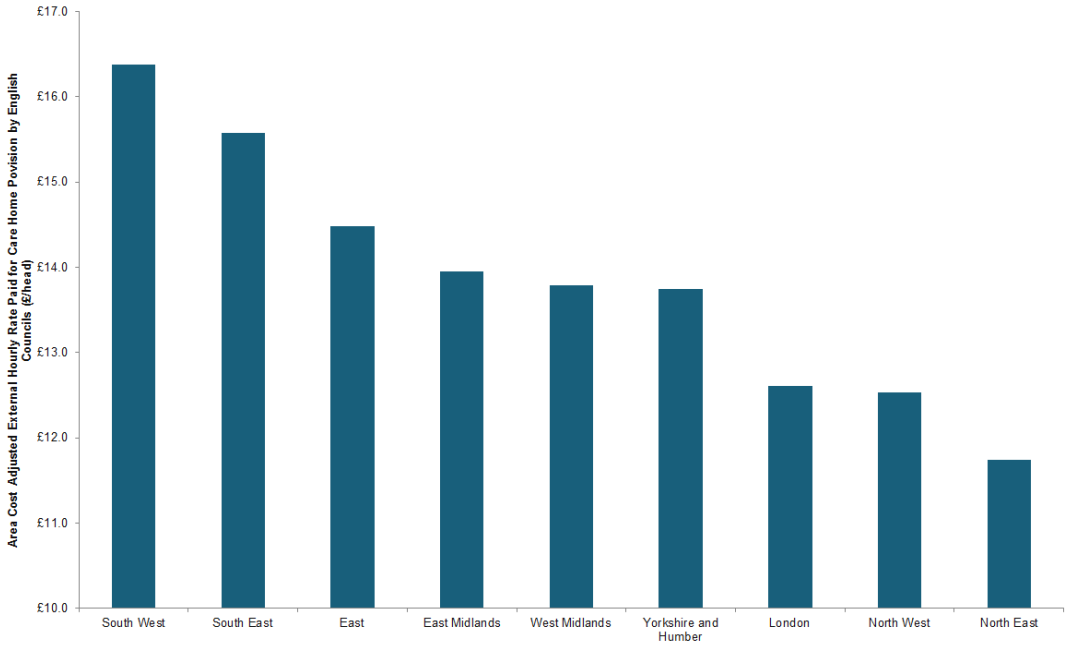


[44] SIGOMA (2017)., Driving Growth in Municipal Areas p5
[45] MHCLG (Feb 2018)., Final local government finance settlement 2018 to 2019
[46] SIGOMA (2017)., Driving Growth in Municipal Areas p5
[47] MHCLG (Feb 2018)., Final local government finance settlement 2018 to 2019 The £150 million for an Adult Social Care Support Grant announced in 2018-2019 for example
[48] National Audit Office (2018)., The adult social care workforce in England, p5
[49] A prominent social care market intelligence provider
[50] Tim Jarrett., The care home market (England), The House of Commons Library p6 NB: Local Authority level data on this split does not currently appear to be collected

9.3 They estimate that self-funders pay, on average, a 43% premium compared council-funded rates. They also conclude that: “Most councils responsible for supporting publicly funded residents do not have the budgets to pay a reasonable cost for care…”

“The entire care home sector for older people is being kept afloat through cross-subsidies... We have conservatively estimated the shortfall in council paid care home fees at about £1.3 billion a year in England alone.”[51]

9.4 As can be seen from the graphs above and below, those areas with low proportions of self-funders are also paying care providers significantly lower hourly rates. While counties pay £15 per hour, the national average is £14 and the SIGOMA average less than £13, even after an area cost adjustment has been applied.[52]



9.5 This is threatening the long-term sustainability of care home providers,[53] increasing demands on low-paid care workers and having a likely knock on effect for the care quality experienced by residents.

9.6 It is also has a market-shaping influence. According to the Competition and Markets Authority; “Nearly all new care homes being built are in areas where they can focus on self-funders… there will be a need for additional funding to support further care homes that would not be sustainable without the benefits of this price differential.”

9.7 Reliance on the private sector in the context of insufficient and unbalanced funding is therefore problematic for future sustainability, particularly for deprived SIGOMA authorities.

9.9 If left unchecked, these market pressures, influenced by the uneven impact of austerity, will continue a worrying trend. Profitable modern facilities will be built in affluent parts of the south, while other areas face deteriorating care home quality and provider collapse.[54]

[51] LaingBuisson (Jan 2017)., Care home funding shortfall leaves self-funders filling £1.3 billion gap
[52] NHS Digital (Oct 2016) Personal Social Services: Expenditure and Unit Costs, England - 2015-16
[53] The Guardian (Dec 2017)., Urgent talks over future of Four Seasons care homes in UK
[54] According to commercial estate agents Knight Frank; “The Southern regions are desirable for care home operators and developers due to the stronger affluence profile of the areas, coupled with demand for modern purpose-built facilities, fit for the 21st century. Furthermore, 58% of income is derived from private revenue in both the South East and the South West...” Knight Frank (2017)., Care Homes Trading Performance Review p5

9.10 SIGOMA supports the principle that residents should receive the same standard of care from their authority regardless of where they live.

9.11 Means-testing is an inevitable aspect of service provision, but cross-subsidisation is creating an additional hidden layer of council funding and a distorted picture of the cost to councils. It affects the quality of services to those dependent on council support and must be recognised in Government subsidy.

10.0 Sustainability of staffing

10.1 Social care workers face physically and mentally challenging working conditions, low pay, little training, few opportunities for career development, and low prestige.[55]

10.2 According to the National Audit Office, these factors influenced a 27.8% turnover rate across all care jobs in 2016-17 with a 6.6% vacancy rate for jobs across the sector in the same year, [56] which could "disrupt the continuity and quality of care… for service users and also mean providers incur regular recruitment and induction costs".[57]

10.3 Under the Care Act, local authorities must have regard to both "the importance of ensuring the sustainability of the market" and "the importance of fostering a workforce whose members are able to ensure the delivery of high quality services."[58]

10.4 However, the NAO also notes that "given… the negative consequences if a provider left the local authority funded market, [local authorities] were cautious about challenging providers over their investment in workforce development." [59]

10.5 In the present context of insufficient funding, these statutory duties therefore come into conflict.

10.6 It is little surprise then that, according to a 2017 ADASS survey, completed by 95% of social care directors, only 3% stated that they were fully confident that they will be able to meet their statutory duties relating to care in 2019-20."[60]

10.7 According to the NAO, "Four-fifths of local authorities are paying fees to providers that are [now] below the benchmark costs of care."[61] All SIGOMA authorities fall within these bottom four-fifths.[62]

10.8 The sustainability of the care workforce is also predicated, on care providers' short-term ability to access a sufficient pool of workers. The rights of non-British care workers following Brexit will therefore be an important consideration.

10.9 According to the NAO; "In 2016, 7% of the care workforce and 16% of registered nurses were non-British EEA nationals."[63]

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[55] National Audit Office (2018)., The adult social care workforce in England
[56] Op. cit. p4
[57] Op. cit. p7
[58] Care Act 2014, p5
[59] National Audit Office (2018)., The adult social care workforce in England p45
[60] Op. cit. p9
[61] National Audit Office (2018)., The adult social care workforce in England p10
[62] Ibid.
[63] Op. cit. p8

10.10 The Government's current position would appear to be to treat EU nationals arriving in Britain after March 19th 2019 "differently" to those that arrived before, though it is unclear what this might mean in practice.[64] It is therefore important to consider whether Brexit may reduce providers' access to the present pool of non-British EEA workers.

10.11 Government must address the potential false economy of high staff turnover, encouraging and enabling its reduction by fully funding councils, strengthening their commissioning power to improve workforce conditions.

10.12 The Department of Health and Social Care must also update its care workforce strategy, incorporating the potential impact of Brexit.

11.0 Lack of certainty

11.1 In order to commit to invest-to-save initiatives, which may be more costly in the short-term but deliver savings in the long-term, councils must be given greater funding certainty.

11.2 This would give procurement teams the flexibility to negotiate longer contracts at more competitive rates, putting them in a stronger position to stipulate terms to better encourage the improvement of facilities, working conditions and overall care quality.

11.3 The recent trend of announcing additional care funding once local authority budgets have already been set, and requiring this to be used in-year, however, means limited resources are being distributed in a manner that also limits the extent which they can be used to shore-up the long-term sustainability of the sector. [65] This uncertainty exerts a similar pressure on private providers.[66]

11.4 One-off funding allocations also increase pressures on local authorities' relationship with care providers. The announcement of additional funding pots acts to heighten the expectations of the provider market when it comes to renegotiating contracts, as providers fail to appreciate the scale of ongoing cuts (for example to RSG) that continue to all but wipe out apparent Settlement or Budget funding increases and tax flexibilities in practice.[67]

11.5 Government must improve efficiency by giving councils (and therefore providers) the long-term funding certainty they need to plan ahead.

12.0 Interdependence of health and social care

12.1 According to Simon Stevens, CEO of NHS England, "there is a strong argument that, were extra funding to be available… it should be going to social care."[68]

12.2 One of the main problems currently faced by the NHS is bed-blocking due to a shortage of suitable care elsewhere.[69] The underfunding of social care therefore has a direct impact on NHS capacity and overall costs.[70]

12.3 We are also concerned that a heavy emphasis on delayed transfer of care targets, and the questionable carrot and stick methods employed to drive reductions,[71] suggests

[64] The Guardian (Feb 2018)., Brexit weekly briefing: new demands threaten transition, says Barnier
[65] As can be seen in the 2018-19 Local Government Finance Settlement
[66] According to the Competition and Markets Authority; "The current funding situation combined with uncertainty about future funding and policy direction means that investors are reluctant to invest in additional capacity focused on LA-funded residents." Competition and Markets Authority (Nov 2017)., Care homes market study: summary of final report
[67] LGA (Feb 2018)., Extra council tax income in 2018/19 will not protect under-pressure local services
[68] The Guardian (June 2016)., NHS boss says promise of £8bn in extra funding may be far from enough
[69] The long-term occupation of hospital beds, chiefly by elderly people
[70] The occupation cost of a single NHS bed is intuitively higher than one in a residential care setting
[71] Local Government Chronicle (July 2017)., DTOC discord is latest backward step in the integration drive

Government increasingly views social care through the prism of the NHS. This current focus should not be allowed to blinker their green paper to wider sectoral issues.
12.4 This perspective may also be common to some CCGs. The focus on protecting more visible NHS budgets it is of course understandable, but it will be appreciated that this can often only be achieved at the expense of social care budgets. The green paper should therefore seek to highlight the extent to which social care can and does relieve pressures on the NHS and explore whether a shift in focus towards prevention, through care in the community, might prove more efficient than cure.

12.5 Government continues to see a situation where health costs reduce but social care costs increase as a "win". While this may be true overall, the lack of an appropriate funding mechanism to share overall savings between health and social care means every saving social care generates for the NHS stays within the NHS, limiting the resources available to social care to generate future efficiencies.

12.6 The Government's Transforming Care[72] policy, for example, can place greater budgetary pressures on social care services as a result of the notable time lag associated with winding up more costly NHS provision. Though principally concerned with younger adults, the lack of "proven and timely ways to enable the funding to follow the patient"[73] identified be the National Audit Office is nevertheless a point of concern for local authorities and must therefore receive due consideration in the Government's forthcoming green paper.

12.7 Currently public health and social care budgets are also ring-fenced, preventing both bodies from having full agency over the management of interrelated pressures or the ability to appropriately balance such asymmetries through mutual agreement.

12.8 Lack of clarity regarding the sufficiency and long-term certainty of funding may also be hindering the efficient integration of services. Greater assurances in this area would allow both councils and the NHS to focus solely on the most efficient means of delivery as opposed to their respective underfunding concerns.

12.9 Government should therefore consider how a lack of resources can limit the efficiency of local working relationships, inhibiting the achievement of its policy aim of greater integration.

12.10 The ring-fencing of public health monies should also be removed to give both councils and the NHS greater freedom to focus resources where they are most needed. Health bodies should also be obligated to offer up the savings that have been generated through social care efficiencies to reinvest in cost-saving social care provision.

13.0 Recent policy proposals
13.1 The Conservative party's election manifesto proposals included:

[72] https://www.england.nhs.uk/learning-disabilities/care/
[73] NAO (March 2017)., Local support for people with a learning disability p11

Policy	Current position	Proposals
Capital means-test	Upper limit – £23,250 Lower limit – £14,250	Single limit – £100,000
Contribution towards cost of social care	Unlimited	Capped
Value of home included in capital means-test for those receiving domiciliary care	No	Yes
Domiciliary care recipients whose home is included in the means-test are eligible for a deferred payment arrangement	Not applicable	Yes

[74]

13.2 The proposal to create a single capital floor at more than four times the current means tested threshold would significantly increase eligibility for local authority funded care and therefore local budget pressures.[75]

13.3 Including the value of a person's home in a capital means test could have fundamentally unbalanced impact on councils, with deprived areas likely seeing a negligible relative benefit.

13.4 Median total household wealth for example in some parts of the country, is more than twice that of others,[76] while median wealth tied up in property can be around 10 times higher in some London Boroughs than some SIGOMA authorities.[77]

13.5 Social care is in crisis because local authorities face reduced funding and increasing cost pressures. Any measures that increase eligibility for council funded care increase those pressures while doing nothing to address the funding issue.

13.6 Government must therefore establish a way to fairly raise further revenue for local authority funded care.

13.7 Should Government choose to include property value in means-testing, the proceeds of any asset sales could be pooled via national changes to capital gains tax and redistributed according to need in order to balance vast local disparities in property values.

14.0 Rebalancing productivity and tackling persistent deprivation

14.1 Affluent residents tend to make fewer demands on state-funded care and contribute more to the tax system which pays for it.

14.2 Yet, there remains a persistent imbalance in affluence across the country, with 96% of SIGOMA members experiencing higher levels of deprivation than the national average.

14.3 Localised affluence is the product of good schools, good jobs, good transport links etc. These are areas which local authorities can influence but only so far as budgets allow.

14.4 Historically, the former industrial areas and coastal port authorities we represent were among the most productive in the country, but a lack of investment in infrastructure or

[74] House of Commons Library (Jan 2018)., Social care: the Conservative Party's 2017 General Election pledges on how individuals pay for care (England) p2
[75] Op. cit. p4
[76] Office for National Statistics (Dec 2015)., Property wealth, Wealth in Great Britain, 2012 to 2014, Figure 3.12
[77] Office for National Statistics (Dec 2015)., House Price Statistics for Small Areas: year ending Quarter 4 1995 to year ending Quarter 2 2015, Map 1

encouragement of new industries by central government has allowed the divide between affluent and deprived areas to widen.

14.5 Now, only London, the South East and, to a lesser extent, the East of England are net contributors to the Treasury.[78] This limits our country's economic potential and therefore our ability to fund care sustainably.

14.6 The issue of social care funding cannot therefore be divorced from Government's stated policy objectives regarding productivity and regional rebalancing.

14.7 Giving residents across the country the same opportunities to build wealthier, healthier lives in practice will help to increase tax revenues and general affluence everywhere, reducing pressures on the social care system.

14.8 Government must therefore press ahead with its manifesto commitments in these areas, the realisation of which will be essential to the long-term sustainability of the care system.

15.0 Who should pay?

15.1 The issue of who should pay is fundamentally a political one, for central government to decide.

15.2 In formulating tax policy, the government should seek an appropriate balance between the tax payer and the client. Having decided on the level of service a client should receive and assessed their contribution, funding levels should not be determined by where the client lives.

16.0 Avoidable costs

16.1 Some aspects of care provision, for conditions such as dementia, represent much greater long-term costs than others. Research into the prevention, management and even cure of such conditions will therefore be crucial.

16.2 Investment in new assistive technologies may also be key for increasing the efficiency with which care can be delivered. Local government can and does share best practice in these areas but their scope to innovate is limited by funding concerns.

16.3 Government may consider commissioning research into how care services might be delivered more efficiently to better understand the costs and planning involved in the most effective invest-to-save initiatives. They must then ensure local authorities are fully funded to deliver any policy objectives they may take forward.

Q2) What should be the mechanism for reaching political and public consensus on a solution?

17.0 Achieving agreement

17.1 The mechanism for arriving at a solution must involve local government. The development of the green paper is being overseen by an "Inter-Ministerial Group" which contains only one representative with a local government background (within a county council).

[78] The Guardian., London economy subsidises rest of UK, ONS figures show

17.2 Greater and more balanced representation is therefore needed from the LGA and representatives of Metropolitan Boroughs and Unitaries.

18.0 Conclusion

18.1 Increasing social care pressures are a long-term problem that will not go away. The current funding crisis faced by local government (following austerity cuts of 40%), however, can and must be addressed.

18.2 This must be done through a needs-based formula that takes full account of variations in local resources and revenue raising capacity and remedies the fundamentally asymmetric impact of the care crisis on councils to date.

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