COUNTY APPG INQUIRY:
INTEGRATED CARE & SUPPORT: THE FUTURE OF ADULT SOCIAL CARE IN COUNTY AREAS
Response of:
South East Strategic Leaders (SESL)
South East England Councils (SEEC)
South East Councils Adult Social Care (SECASC)
12 SEPTEMBER 2014

EXECUTIVE SUMMARY

1. This is a joint response of South East Strategic Leaders (SESL), South East England Councils (SEEC) and South East Councils Adult Social Care (SECASC) which represent County, Unitary and District authorities across the South East and over 8.8m residents. SESL, SEEC and SECASC welcome the opportunity to respond to this inquiry. We hope this response helps to highlight the significant challenges and opportunities particular to the South East and to inform a clear, national vision for the future of adequately funded adult social care provision.

2. **Funding formula should take into account the unique combination of South East characteristics**, which present particular challenges and opportunities to delivering integration:
   - **Our large population –** At 8.8m people, the South East has England's largest population, projected to increase to over 10m by 2032. The impact on demand and costs is massive and often masked by percentage comparisons.
   - **Our large elderly and ageing populations** – The South East has England's largest and fastest growing group of elderly and ageing people with those aged over 75 expected to increase to well over 1m by 2024. **Funding should give greater weighting to numbers of older residents than levels of deprivation.**
   - **Our rural population –** The rural nature of much of the South East makes it more costly to deliver public services in sparse, rural areas.
   - **A higher-cost area -** Higher property costs and salaries mean that it costs more to deliver services in much of the South East.
   - **Our high number of self-funders, carers and large prison population** – We have the highest proportion of self-funders (some 55% compared to 45% nationally), 920,796 unpaid carers and over 15% of the prison population, making it more costly and resource intensive to deliver Care Act duties in the South East.

3. **South East councils have the ambition and potential to lead local integration of health, social care and wider public services. We have already made good progress but could go further, faster with the following funding and freedoms:**
   - **Genuine devolution of powers and freedoms** to increase inward investment to support service delivery. Councils should be given powers to set and keep more taxes locally and to introduce small new local fees.
   - **Long term sustainable funding for adult social care** that recognises the unique combination of South East characteristics.
   - **Adequate funding to cover the costs of the Care Act** – both one-off implementation and recurrent costs.
   - **Time and resource investment in an expanded, skilled social care workforce –** national work should be undertaken to consider future demand on the workforce and how this will be met across the whole market.
   - **Responsibility for NHS estate management and procurement** freeing up more patient focused health professionals.
   - **Strengthened influence to encourage Clinical Commissioning Group cooperation.**

4. South East councils are leading efforts to deliver integration of health, social care and wider public services. Local efforts could be supported by:
   - **Further Government incentives for blue light integration under local authority leadership.**
   - **Greater acknowledgement of the vital role of District Councils in two tier areas and all councils' public health responsibilities**, which should be explicitly recognised in the Care Act regulations and guidance.
   - **National political leadership to rewire financial incentives to support a shift away from acute care and towards community-based care.**
   - **A single commissioned, single budget for health and social care managed by council-led partnerships.** The Better Care Fund is a step towards this but proposed changes to the Fund could undermine local integration efforts and we urge Government to reconsider these.
   - **Ensuring that the Care Act regulations and guidance support integration by removing potential for disagreements and cost shunting.**

MAIN SUBMISSION

SOUTH EAST BARRIERS AND CHALLENGES TO INTEGRATED HEALTH AND SOCIAL CARE (1)

5. **The unique combination of South East characteristics presents several significant challenges to delivering health and social care integration as well as opportunities:**

5.1. **Our large population -** At 8.8m people, the South East has England's largest population, approximately 400,000 more residents than London and greater than Wales and Scotland combined. Our population is projected to grow by 1m, increasing to over 10m by 2032. This presents significant demand and resource challenges for South East councils. One particular challenge is unmasking the true impact of our vast population, which is often hidden by percentage comparisons instead of looking at absolute numbers. For example, the South East has 248,901 people over 60 years old living in income deprivation, some 13% of the older population. In contrast, the North East has a higher percentage of older people in income deprivation at 23.3% but this translates into significantly fewer people at 138,442. Government formula has tended to prioritise deprivation measures over other factors without questioning whether they are always appropriate or proportionate and, consequently, has overlooked the impact on services of the South East's vast and growing population. To rebalance this, **funding formula for health and social care should give greater weighting to absolute numbers of older residents and place less emphasis on levels of deprivation.**

5.2. **Our large elderly and ageing populations -** The South East also has England's largest and fastest growing group of elderly and ageing people. By 2024, those aged 65+ will increase from 1.6m to over 2m and those aged 75+ will increase from nearly 800,000 to well over 1m. While we do not underestimate the contribution that this group makes to society, including through paid or unpaid roles in business and the community, the sheer scale of our population and number of elderly residents places significant demand and cost pressure on South East councils. This impact is exacerbated by increasing complexity of health and care needs.

5.3. **Our rural population –** The rural nature of much of the South East makes a positive contribution to people's health, wellbeing and quality of life. It is, however, more costly to deliver public services in sparse, rural communities, an issue that is widely documented and currently the focus of a joint DEFRA – DCLG review. Costs incurred in the South East include: travel costs, limited economies of scale and the need for more service delivery hubs. These factors need to be recognised in funding formula.

5.4. **Higher-cost area -** Higher property costs and salaries mean service delivery costs are higher in the South East. This South East premium needs greater recognition in funding formula.

5.5. **High numbers of self-funders -** Estimates based on self-funders in residential care suggest that the South East has more self-funders than other parts of the country. The King's Fund states that the South East has the highest proportion of self-funding care home residents at 55%. Surrey County Council estimates around 80%, substantially more than the UK average (approx. 45%). This presents a large group who could approach councils for assessment and support under the reformed care system, which will impact significantly on council resources.

5.6. **High numbers of carers and prison population –** The high number of carers in the South East and our large prison population are further challenges to implementing new duties under the Care Act. There are 920,796 unpaid carers in the South East, 634,445 more than the North East (286,351). The South East has over 15% of the prison population at 12,941 prisoners. Kent and Surrey, in particular, have a large prison population, 5,342 and 2,351 people respectively.

GOVERNMENT MEASURES TO OVERCOME CHALLENGES AND BARRIERS TO INTEGRATED CARE AND SUPPORT IN THE SOUTH EAST (2)

6. **South East councils have the ambition and potential to lead the local integration of health, social care and wider public services and are already driving forward the local integration of services for the benefit of our residents; however, we could go further, faster with the following funding and freedoms:**

6.1. **Genuine devolution of powers to raise local finance –** South East councils are already innovating to raise local funds to support service delivery, with some authorities, such as Aylesbury Vale District Council, on track to become financially self-sufficient. **Genuine devolution of powers and freedoms to increase inward investment would enable South East councils to become even more commercial, unlocking income to reinvest in local services. Councils should be given powers to set and keep more taxes locally, such as business rates, stamp duty and council tax, and to introduce small new local fees if agreed locally.**

6.2. **Long term sustainable funding –** The unique combination of the South East's characteristics is increasing demand for council services, which is pushing up costs at a time when councils are having to reduce their budgets. SESL and SEEC County and Unitary authorities have already taken £1.3bn out of their budgets since 2010 and estimate that a further £1.4bn is needed by 2017/18. Nationally, the Local Government Association (LGA) estimates that the funding gap between March 2014 and the end of 2015/16 for adult social care is £1.9bn and the Association of Directors of Adult Social Services (ADASS) estimates that £3.53bn has already been taken out of adult social care budgets nationally over the past four years. Efficiency measures, sharing services, service integration and a shift towards prevention are all vital but these measures alone will not meet the scale of demand and cost pressures on South East councils' social care budgets. **Government must identify a long term, sustainable funding solution for social care with a funding formula that recognises the scale of costs faced in the South East.**

6.3. **Adequate implementation funding –** The Care Act is a necessary and welcome piece of legislation that will have significant resource implications for local authorities, particularly councils in the South East. Kent County Council estimates the implementation and ongoing running costs associated with the Care Act to be £22m per year, potentially rising to £45m depending on the regulations and levels of self-funders approaching the council for support. Buckinghamshire County Council indicates there could be an additional minimum cost of £17m in the first year, potentially rising to £45m before the impact of the care cap takes effect.

6.4. While additional implementation funding has been made available for some of the 2015/16 costs, including for new prisoner duties, increased assessments and deferred payments, there remain some new duties, such as duties towards carers, that have not yet been allocated funding but which will have significant impact in the South East. We are also concerned that the Care Cap and other Dilnot-related changes due to commence in 2016, will place significant costs on South East councils, potentially over and above those faced by other areas due to our higher than average number of self-funders[1]. **It is important that implementation funding for 2015/16 and 2016/17 is sufficient to meet implementation costs in full and extends beyond this to also cover on-going new duties. Where evidence shows this not to be the case, Government must revisit the funding envelope.**

6.5. A further factor that will draw significantly on South East council resources is the need for a larger, skilled social care workforce to meet the needs of our growing elderly and ageing populations and to implement new duties under the Care Act. This is a particular challenge for our members due to the South East premium. **We recommend that national work is undertaken to consider future demand on the workforce and how this will be met across the whole market.** National work should be used to evidence the most effective use of social work staff, taking into account the aim of reforms to enable individuals to do more for themselves, drawing on informal support networks. **The time and financial investment needed to train the workforce should also not be underestimated.**

6.6. **Strengthened influence and greater responsibility –** South East councils have a successful track record for driving efficiencies from procurement and estate management; for example Hampshire County Council's One Public Sector Estate Programme is set to deliver circa £270m savings from asset rationalisation. Based on success to date, **South East councils are well placed to take on responsibility for NHS estate management and procurement, freeing up more patient focused health professionals**. Secondly, although South East councils are generally working very effectively with CCG colleagues and GPs, we believe that **councils' influence should be strengthened to encourage Clinical Commissioning Group cooperation**.

SOUTH EAST VISION: OPPORTUNITIES AND MEASURES TO SHAPE THE FUTURE OF ADULT SOCIAL CARE PROVISION (3)

7. **Our vision is for the full integration of public services locally – health and social care integration is a key part of this but not the sum total. The section below also includes examples of measures local partners can use to better integrate care and support.**

7.1. Our ambition is to see adult social care provision fully integrated with health as one part of a wider integration of services locally that extends to include, for example, public health, housing, environment, leisure, employment

[1] There is a significant difference between the rate paid by council-placed and private residents. Under the reforms, particularly due to the increase in the upper threshold for means tested support to £118,000, more people will be eligible for council funding and a significant number of self-funders are likely to opt for their local council to arrange their care. Additional people are likely to expect to pay the council rate for residential care rather than the higher private rate. This will put pressure on providers who may attempt to increase the rate that local authorities pay for residential care placements, raising council costs significantly.

and emergency services. Democratic, locally-led councils are well placed to lead local integration of health, social care and wider public services. South East councils are already demonstrating how local measures are driving forward integration opportunities as the following mini case studies illustrate[2]. **Government could further support local efforts by incentivising the integration of local blue light services in the South East under local authority leadership.**

How South East councils are leading the integration of health, care and wider public services:

Since 2011, **Kent County Council's Health and Social Care Integration Programme** has been operating across Kent within Clinical Commissioning Group (CCG) areas to improve experience and outcomes for service users. New Health and Social Care Coordinators (HSCC) provide a single point of contact for GPs and patients and signpost individuals to services in the community provided by voluntary or not-for-profit organisations. HSCCs work with neighbourhood care teams where multi-disciplinary team working is taking place in GP surgeries, resulting in positive outcomes, such as helping patients to access services in a timely manner and preventing unnecessary emergency admissions. The Council is committed to working with District councils, the voluntary sector and other care providers to make integrated care happen and local Health and Wellbeing Boards, which include District and Borough councils, operate locally.

Oxfordshire County Council's Fire and Rescue Service is working in partnership with the Council's Social and Community Service to provide targeted fire prevention support to vulnerable households. The integrated service was developed during 2011 and established as the Combined Care Service in 2012. The service seeks to make the best use of available data on social care clients to identify vulnerable people not known to the fire and rescue service so that action can be taken to make them safer in their own homes, thereby reducing the number of fire deaths. The service has created a platform from which to collaborate with other stakeholders, such as Age UK Oxfordshire, enabling the fire service to improve the community engagement aspects of its risk reduction work.

7.2. **The full integration of health, social care and wider services will only be achieved by recognising the vital role of District councils in two tier areas and all councils' public health responsibilities.** In two tier areas, where District and County Councils operate, many preventative services are the responsibility of District Councils, for example housing. Full integration in two tier areas therefore necessitates a greater acknowledgement of the role that District councils play in providing services that encourage good health and enhance wellbeing. **Care Act regulations and guidance should explicitly recognise the role of District Councils and reflect a greater acknowledgement of the public health role of all councils and their wider preventative work**.

How South East councils are leading preventative work locally:

Oxford City Council is working in partnership with leisure provider Fusion Lifestyle to improve the health and wellbeing of older residents by encouraging them to take part in subsidised fitness activities, including fitness classes, 50+ swimming sessions, 50+ badminton and racquetball and Nordic walking. Since March 2009, over 339,000 visits have been made by older people to leisure facilities and by the end of 2013/14 the council had achieved a 112% increase in visits to its leisure facilities compared to 2009. The City Council also works with Oxfordshire public health to offer an Exercise on Referral scheme to patients.

Buckinghamshire County Council is reducing costs by providing early, preventative, community-based help for people with moderate care needs. The council's programme **Prevention Matters** was co-designed with over 100 partners and aims to maximise the impact of early intervention and reduce the anticipated increase in the councils' expenditure on social care by 25% through to 2016. This will be achieved by: motivating adults with low to medium social care needs to remain active; improving access to services and building community capacity to support services; gathering intelligence about service users needs' in order to better target resources; and supporting volunteering.

7.3. **As well as becoming more focused on early intervention and prevention, adult social care provision should be increasingly delivered in the community rather than acute or institutional care settings**. South East councils are working to build greater community capacity and to boost volunteering so that individuals are equipped to take greater responsibility for meeting their own needs, drawing on informal family and community support networks. Government could support further action by councils in this area by switching funding from NHS acute services to local preventative work.

[2] More detailed information on all of the mini-case studies included in this response is available in SESL and SEEC's publication *Making Integrated Care Happen* (Aug. 2014)

7.4. Despite councils' success in building community capacity and reducing the number of days which patients spend in acute care, hospitals continue to admit patients to vacant beds as they are financially incentivised to do so. Consequently, hospital admission rates are not reducing and savings are not being fully realised and reinvested in community-based care. **Government should support the rationalisation of hospital beds and a shift in funding to improve community based care. We need a clear national vision that communicates to residents that such changes are in the public interest**.

7.5. This Government has started to show the kind of leadership needed with the introduction of the Better Care Fund (BCF), a source of funding (albeit not new money) that our members have welcomed. We continue to be concerned, however, that proposed changes to the BCF, whereby funds could be used for NHS services if local integration efforts fail to reduce emergency admissions significantly, will undermine BCF aims to prevent unnecessary admissions and make care funding more sustainable. This weakening of the BCF is particularly concerning as we regard this new Fund as only the first step towards a much larger pooled budget. **We urge Government to reconsider proposed changes to the BCF and to publish a clear description of the framework for delivering a single commissioned, single budget for health and social care managed by council-led partnerships.**

How South East councils are reducing demand for high cost, acute services:

Royal Borough of Windsor and Maidenhead's Carebank project uses time credits, such as free use of a leisure centre, to encourage volunteering. The scheme has been rolled out with the help of the Royal Voluntary Service. In its first year over 1,900 hours of support were delivered, creating over £60,000 of benefit to volunteers and users. Benefits to users, including befriending and support services, are estimated to exceed £50,000. For volunteers, reward credits were worth over £10,000. Excluding one-off set up costs, the pilot delivered £1.20 to £1.30 for every £1 invested. The scheme has also attracted a greater number of younger volunteers.

Hampshire County Council is investing £45m in extra care assisted living schemes to provide a viable, county-wide alternative to residential care for older people, reducing the likelihood of these individuals entering institutional accommodation or being hospitalised, increasing positive health outcomes and reducing falls. Since 2007 the Council has developed 4 extra care assisted living schemes, offering 240 units in Andover, Gosport, Fleet, and Basingstoke, with more schemes to come. The Council will not build or run the schemes but will identify sites for development, provide financial support and offer contracts for care services.

7.6. **It is vital that the regulations and statutory guidance that accompany the Care Act support this vision for an integrated system by removing potential for disagreements and cost shunting**; for example, by upholding a clear boundary between NHS services, free at the point of use, and local authority means tested social care, or by clarifying whose responsibility it is to fund joint aftercare services for patients with mental disorders under S.117 of the Mental Health Act 1983. These, and other examples, are detailed in our joint response to the DH consultation on Part 1 of the Care Act[3].

[3] http://documents.hants.gov.uk/sesl/ConsultationResponsePart1CareActAugust2014.pdf

ABOUT US

South East Strategic Leaders (SESL)

SESL is a partnership of upper tier authorities committed to nurturing the engine room of the UK economy and promoting public service excellence. SESL supports its members to create the conditions within which individuals, communities and businesses thrive. We aim to:

- **Influence** – speaking with a stronger, united voice for South East strategic councils.
- **Inform** – producing robust evidence relevant to practice.
- **Inspire** – connecting people, sharing ideas, sparking innovation.

SESL is chaired by Cllr David Burbage MBE, Leader of Royal Borough of Windsor and Maidenhead.

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South East England Councils (SEEC)

South East England Councils (SEEC) was established in 2009. It is a membership organisation representing all tiers of local authority. The SEEC area covers Berkshire, Buckinghamshire, East and West Sussex, Hampshire, Isle of Wight, Kent, Oxfordshire and Surrey. SEEC's objectives are:

- To strive for a fair funding deal for the South East
- To promote the South East's position as a leading global economy
- To act as single democratic voice for South East interests
- To monitor the pulse of the South East.

SEEC is chaired by Cllr Gordon Keymer CBE, Leader of Tandridge District Council.

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South East Councils Adult Social Care (SECASC)

The SECASC group is made up of 19 local authorities (Single Tier and County Council) with adult social care responsibilities. The group has been established to inform regional and national debate, sharing good practice information between Lead Members, as well as raising the general profile of adult social care issues.

SECASC is chaired by Cllr Patricia Birchley, Cabinet Member for Health and Wellbeing, Buckinghamshire County Council

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