Written evidence submitted by the Local Government Association [ASC 076]

1. About the Local Government Association

1.1. The Local Government Association (LGA) is the national voice of local government. We are a politically led, cross-party membership organisation, representing councils from England and Wales.

1.2. Our role is to support, promote and improve local government, and raise national awareness of the work of councils. Our ultimate ambition is to support councils to deliver local solutions to national problems.

1.3. We welcome the opportunity to provide updated written evidence to the Committee as we were sadly unable to give oral evidence to this inquiry. This is a rare occurrence, and we look forward to giving oral evidence at the next opportunity.

2. Summary

2.1. COVID-19 put adult social care firmly in the public, political and media spotlight. The crisis highlighted the essential value of social care to the wider public and this interest needs to be harnessed in the debate about the future of care and support.

2.2. Years of significant underfunding, coupled with rising demand and costs for care and support, have combined to push adult social care services to breaking point. Over the past decade, adult social care costs increased by £8.5 billion while total funding (including the Better Care Fund) only increased by £2.4 billion. This left councils with a funding gap of £6.1 billion. Of this, £4.1 billion was managed through savings to the service, and £2 billion was managed through funding diverted from other services by cutting them faster than otherwise would have been the case.

2.3. Whilst we are supportive of the introduction of a cap on care costs and other reforms announced as part of the Government's 'Build Back Better' plan for health and social care, we have previously raised our concerns about the adequacy of the announced £5.4 billion to fund these reforms through the new Health and Social Care Levy. The Spending Review and Autumn Budget did nothing to allay those concerns and we are troubled that only £200 million is available in 2022/23 to support reform implementation, particularly if that includes the commitment to move towards councils paying a fair rate of care.

2.4. The Spending Review also did not set out how much of the £5.4 billion will need to be used to pay for the other Government reform commitments, including: action to better support unpaid carers, investment in Disabled Facilities Grant, supported housing and other housing innovations, and improved information and advice. This information is needed urgently so councils have a more thorough understanding of the work that will be expected of them over the coming months.

We were hoping that the Spending Review would clarify the funding available for reform and, even more importantly, tackle the long-term financial sustainability of social care which is so desperately needed. Social care's core cost pressures amount to £1.1 billion in each year of the Spending Review period and come on top of a pre-existing and annually recurring pressure of £1.5 billion to stabilise the care provider market (the difference between what providers say is the benchmark cost of providing care and what councils pay). These pressures are in addition to the many other challenges facing social care, such as the need for greater investment in prevention and action on care worker pay and conditions.

2.5. The additional £1.6 billion per annum for local government overall needs to be seen in this context and brings into question the Government's assertion that the settlement will enable councils to meet all of their social care core pressures. A greater proportion of the Health and Social Care Levy should be used to support frontline social care, to stave off the worst of the pressures and provide a degree of stability for the short- to medium-term.

2.6. Without proper long-term investment it is likely that councils will continue to struggle to meet their statutory duties under the Care Act, with real consequences for people. More people who draw on social care will be unable to live an equal life; more people will live with unmet care needs; unpaid carers will experience further deterioration of their mental, physical and emotional wellbeing; the care workforce will remain under unbearable strain, with more likely to leave the sector; and providers' financial viability will be tested to the extreme, with more likely to exit the market or hand back their contracts with councils.

3. What are the funding pressures on adult social care; how, if at all, have these changed since the Committee did its joint report with the Health Committee in 2018; what has been the impact of the pandemic on these pressures?

3.1. Over the previous decade, adult social care costs rose by £8.5 billion, taking into account rising demand and prices, while total funding, including the Better Care Fund (BCF) only grew by £2.4 billion. This has left councils with a funding gap of £6.1 billion.

3.2. Of this, £4.1 billion was met by making savings to adult social care services, whilst a further £2 billion was diverted from other council services, cutting them faster than otherwise would have been the case.

3.3. Analysis by the Institute for Fiscal Studies (September 2020) suggests that an immediate injection of funding of at least £1.5 billion is needed to enable councils to provide short term stability and avoid serious risks to the adult social care provider sector.

3.4. For future years, the baseline for social care must cover irreducible costs, and account for other costs including inflation, demographic changes and National Living Wage, which councils have to accommodate in order to avoid building up further pressures in the future. These costs are estimated at an additional £1.1 billion per year, to keep services running at 2019/20 levels. It should be noted that since we calculated these core pressures, the inflationary element has increased; it is therefore likely that the £1.1 billion figure underestimates the true scale of the pressure.

3.5. In addition to funding core pressure there is an urgent need to address the levels of pay in the care sector to support recruitment and retention and properly reward the valued role of care workers. Any changes to pay and reward would need to be fully funded by central Government as there is no resource in the sector to meet the demands of this challenge. It will be important to assess the best form of comparison with the NHS on basic pay and resulting costs as overall costs could be in the region of £1 billion. In addition, there is a need to invest in prevention and to make inroads into unmet and under-met need.

3.6. Whilst we are supportive of the introduction of a cap on care costs and other reforms, we have previously raised concerns about the adequacy of the announced £5.4 billion to fund these reforms through the new Health and Social Care Levy. The Autumn Budget/ Spending Review did nothing to allay those concerns and we troubled that only £200 million is available in 2022/23 to support reform implementation, particularly if that includes the commitment to move towards councils paying a fair rate of care.

4. What is the impact of the pandemic on adult social care funding pressures?

4.1. It is too early to tell what the exact long-term impact of the pandemic will be on the adult social care cost base, both in terms of demand and cost of provision. But, to give one example, emergency fee uplifts paid to adult social care providers to help keep services running were agreed during the pandemic, and it is difficult to see how they could now be unwound given the fragility of the market and labour shortages.

4.2. The implementation of discharge to assess (D2A) in September 2020 - a process designed to rapidly discharge patients from hospital once it is medically safe and optimal for them to return home - was the right thing to do. For patients that need social care on discharge, a package of care is funded for up to 4 weeks from the Discharge Fund. However, the D2A model has had the effect of increasing demand on social care due to:

4.2.1. Higher acuity patients being discharged earlier (more users, higher average value package)
4.2.2. Exhaustion amongst unpaid carers following a period during COVID of bearing a greater weight of responsibility for loved ones
4.2.3. Lower risk tolerance in the NHS and therefore higher packages of care arranged on discharge with less of an emphasis on ‘strengths-based’ assessments
4.2.4. A saturation of the domiciliary care market causing discharges to care homes (at a higher cost) increasing dramatically
4.2.5. No extra funding for social care has resulted in a backlog of patients waiting to be assessed for their longer-term destinations and remaining far beyond the imagined four weeks in a temporary placement. This has resulted in significant backlogs of higher cost people in the wrong place.
4.2.6. Discharge to assess funding is due to come to an end at the end of March creating a further pressure on social care budgets.

5. How far does the Build Back Better Plan address the pressures in adult social care? Is the £5.4 billion earmarked for adult social care sufficient for the announced reforms?

5.1. The Government’s 'Build back better' proposals for reforming and funding social care, are a potentially important first step in changing the way social care is paid for by people who draw on social care.

5.2. The publication of a new White Paper by the end of the year will hopefully provide much needed clarity to communities. There however, remain questions about the plan and whether it will make the kind of progress councils want to see to best support people who draw on adult social care.

5.3. There is nothing from the £5.4 billion for frontline adult social care that will help address the immediate pressures facing the sector. We have therefore called for social care to receive an immediate share of the Levy to deal with urgent pressures, as per the use of the fund for the NHS.

5.4. It was disappointing that the Autumn Budget and Spending Review did not set out how much of the funding will go to social care. We are also troubled that only £200 million is available in 2022/23 to support reform implementation, particularly if that includes the commitment to move towards councils paying a fair rate of care.

5.5. The Spending Review also did not set out how much of the £5.4 billion will need to be used to pay for the other Government reform commitments, including: action to better support unpaid carers, investment in Disabled Facilities Grant, supported housing and other housing innovations, and improved information and advice. This information is needed urgently so councils have a more thorough understanding of the work that will be expected of them over the coming months.

5.6. The Plan also includes no detail about either the profile of the £5.4 billion over the three-year period; or the allocation social care can expect to receive beyond the three-year period.

5.7. On charging reform, the Plan states that the funding for social care covers the costs of, "implementing the charging reforms, including the cap, the increased capital limit, moving towards paying a fair rate of care and the associated implementation costs".

6. Care costs cap and changes to means test thresholds

6.1. Of the £5.4 billion allocated to social care through the new Health and Social Care Levy, £3.6 billion will be used for the care costs cap and more generous means test thresholds and £1.7 billion will be used for wider system reform (which we understand includes the £500 million for measures to support the care workforce).

6.2. When a previous government was preparing for the implementation of Part Two of the Care Act, their Impact Assessment set out costs amounting to £1.2 billion. If the estimates of the previous Impact Assessment were uprated by inflation and demand changes, we estimate the costs would be £1.62 billion over the three-year period.

6.3. We know from past experience that preparing for implementation of these measures will be a huge undertaking for councils and they must be supported with whatever is needed to deliver the Government's commitments.

7. Are councils planning to raise council tax to address immediate funding pressures in social care?

7.1. We do not have intelligence on councils' council tax plans. However, at the Spending Review, the Chancellor announced that the referendum threshold for increases in council tax is expected to remain at 2 per cent per year. In addition, local authorities with social care responsibilities are expected to be able to increase the adult social care precept by up to 1 per cent per year.

7.2. Alongside additional funding set out in the Spending Review, the ability to levy an adult social care precept for a further year gives councils the potential to raise much needed resources to help people in our communities who need care and support. However, there will be challenges for councils in explaining to residents why there is an increase in the local council tax/precept as well as the new National Health and Care levy. People will think they are paying twice. In reality, the bulk of funding for adult social care will continue to come from council tax and business rates income.

7.3. Council tax cannot provide a long-term solution to funding social care, as council tax raises different amounts of money in different parts of the country, which is not related to need and which also adds an extra financial burden on already struggling households.

8. After three years, the Government has indicated that social care will receive an increased proportion of the new National Insurance Levy. What does the Government need to consider when sharing the Levy between social care and the NHS?

8.1. Councils need an absolute guarantee from Government that the tax take from the new Levy will make its way to social care. As the Nuffield Trust has said, “taking money away from the NHS is a task that has not been done before”.

8.2. In terms of considerations, it is essential that social care is given the funding it needs to tackle core pressures and the provider market gap, as well as funding to begin tackling the numerous other issues facing the sector, such as care worker pay, unmet and under-met need, greater investment in prevention, better support for unpaid carers, and innovation.

8.3. Government must not fall into the trap of thinking they have ‘fixed’ social care simply by using the Levy to fund the new charging reforms. We understand this is a Government commitment, but it does nothing to bring about the wider changes or funding that are needed so that people who draw on care and support can live an equal life.

9. As employers, care providers will have to pay additional NICs. How could this affect the adult social care market?

9.1. The Build Back Better Plan makes clear that public sector contributions to the Levy will be funded from the tax take (and the overall estimated take of £36 billion is after that compensation is taken account of), to avoid a reduction in the spending power of public services.

9.2. This is helpful, but the Plan makes no reference to, or estimate of, the additional National Insurance Contributions providers may face paying from services commissioned by councils. Councils routinely commission adult social care from a range of partners from the private, independent and voluntary sectors, all of whom will likely expect to see an increase in their fees to reflect their higher NI contributions.

Our very initial analysis suggests that if councils were to cover these additional costs for adult social care providers, it would cost in the region of £89 million per year. The cost pressures arising from commissioned activity across all council services would clearly be considerably higher.

9.3. The exact impact of the National Insurance contribution increase on providers cannot be fully assessed because of unknown variables. These include; if a provider

increases wages to offset staff NICs, the future hours that staff work (which impacts on overall NIC) and crucially, the behaviour of other companies and suppliers that care providers rely on. For instance, a care homes food supplier may increase their prices to cover their increased National Insurance Contributions.

9.4. These additional costs add to the inflationary pressures that face providers which they will, no doubt, seek to cover in fee increases from councils. Early indications from some councils are that inflationary pressures on providers could be as much as 6-7% when NI and NLW increases are taken into account.

10. Will the Government's proposals further destabilise local care markets?

10.1. The rates many care providers charge to people that arrange and fund their own care are greater than those charged to councils for the same type and level of service. This is often referred to as the 'self-funder cross-subsidy' and is an important mechanism for provider sustainability. Under the Build Back Better Plan, the Government states that it will ensure that self-funders are able to ask their local authority to arrange their care for them so that they can find better value care...

10.2. Any change to the way care is commissioned and funded will impact on local care markets. Depending on how and how quickly this change is implemented, we would expect to see some unintended consequences, such as immediate and significant increases in fees charged to councils.

10.3. There is potential to destabilise local markets if councils are unable to afford the increase in fees that providers would need to compensate for the lower rates paid by self-funders.

10.4. Councils are continuing to increase their understanding of care provider costs, which is helping create a transparent and fair relationship between the costs care providers incur and the rates they charge for the services they provide. Government action to support this move towards greater transparency over care provider costs would help create a fair and stable financial position for individuals needing care, care providers and councils.

10.5. Whilst supporting transparency and greater understanding of care provider costs, we think it is important that councils and providers are allowed to work together locally to agree fee structures which work for local conditions and objectives.

11. Charging reform: what are the likely implications and impacts of the Government's plan to bring in a new duty for councils to arrange care for self-funders (Care Act 18.3)?

11.1. Paying a fair rate of care

11.1.1. There is no detail on this aspect of the reforms, although a 'Stakeholder Q&A' notes that the £5.4 billion includes funding to enable councils to move towards paying providers a fair rate and that new guidance on this will be developed. We infer that the Government believes providers should be paid more and that this will help address the current situation where self-funders often pay significantly more than people who are fully or partially funded by councils.

11.1.2. Through existing legislation, the Government will enable self-funders to ask their council to arrange their care to find better value. To make this change sustainable for providers, rates paid by councils would need to increase. Our own estimate of the provider market gap amounts to £4.5

billion over the three-year Spending Review period. This would simply enable councils to pay the full cost of each place or hour of care, without cross subsidy from self-funders, and would not include funding to improve the quality of care.

11.1.3. It is unclear – and probably unlikely given the various commitments the £5.4 billion is expected to fund and the high cost of those commitments and other existing pressures – that moving towards a fair rate of care will fully address the cross-subsidy issue. It is even more unlikely that it will give providers additional income with which to, for example, improve the quality of care or care worker pay.

11.2. What additional support will local authorities need to implement the new means test and cap/floor?

11.2.1. The reforms will require that everyone must be assessed by a local authority if they want the cap to take effect. This was welcomed last time by local government and means that people are provided with independent advice and do not simply assume that going into a care home is the only solution. However, this may mean that more alternatives will need to be available to support people as they start to need some assistance (for example, reinforcing the importance of housing-based solutions, community services and the availability of care workers and others within the community). Local authorities will need to address this in their market management and Market Position Statements.

11.2.2. The reforms will also require more social workers (or others who can assess care needs). In 2015, the Government assumed that people would apply before the cap was introduced to be assessed so that care could start as soon as the cap came into effect. Given the new timetable, this would suggest that people would start to come forward for assessments from April 2023 onwards. Previously, the Government assumed that the cost of the additional assessments would be just over £200 million a year. This funding would need to be part of the funding package provided by the Government for local authorities. However, the much bigger issue may well be the feasibility of finding social workers or others to undertake the assessments given that we are no more than 18 months away from when they need to be in post.

11.2.3. Anybody wanting to be included in the cap and metering system will need to have both a Care Act assessment (to indicate they need care and what care they need) and a financial assessment (to indicate their assets). Both the care management systems and the financial systems will need to be able to cope with changes to build in new ‘rules’ to the engines of those systems to deal with the cap and metering (detail still to be announced) and the complexities of capturing which part of the package of care needs to be disregarded for the purpose of moving towards the cap (for example, living costs, first or third party top-ups, anything outside the eligibility assessment under the Care Act etc).

11.2.4. There are multiple care management IT systems, multiple financial assessment systems and multiple permutations used across the 152 local authorities – all with separate contracts with suppliers. All systems tend to be tailored to the working practices of the local authority who purchased the system and different councils may be on different versions of the same proprietary system. Changes to systems comes at a price, and we are working with NHSX and suppliers to assess this. Additionally:

- Staff will need to be trained

- There is already a shortage of financial assessment officers
- There will be increased demand for care assessments due to former self-funders who were never on the system coming into the system (it could be 40 per cent of service users depending on where you live)
- There will therefore need to be more assessments of both kinds, requiring more staff

11.2.5. Councils will need help with all of this in order to meet the challenging timescales, including any help possible in automating aspects of assessments.

12. How has Government been engaging with local government on the white paper?

12.1. It is crucial that the Government works with councils, their partners and those with lived experience, to build on their proposals and develop a care and support system which is fit for the future.

12.2. We understand there will be eight chapters in the forthcoming System Reform White Paper (workforce; unpaid carers; shaping the care market; models of care; digital and tech; assurance and improvement; housing; information and advice) and the Department has set up engagement advisory groups for each.

12.3. The LGA has helpfully been invited to sit on each group as part of the Department's commitment to coproducing the white paper. On paper, this is good and welcome engagement. However, by committing to publish by the end of the year, the Department is working to a challenging timetable. At the time of writing the white paper remains unpublished but we understand its publication is imminent.

12.4. We therefore hope that the Department also considers the significant amount of work that the LGA (and other national partners) has done on care and support reform. They should not be starting from a blank page.

13. How is integration of health and social care progressing, including Integrated Care Systems (ICSs), and what levers need to be put in place to support greater integration of health and social care?

13.1. Progress on integration

13.1.1. Integration is not a new concept in health and social care; all areas have been joining up care and support for decades. The challenge is to escalate the scale and pace of integration, so it becomes the main way of working.

13.1.2. The Better Care Fund, the only nationally mandated vehicle for integration, has continued to be a driver for closer working and joining up budgets and planning. Since its inception, in many areas, partners have consistently pooled significantly more resources in their BCF than the mandatory minimum contribution. In addition to the BCF, many areas have pooled budgets for mental health, learning disability and using section 75 agreements. This is evidence that many areas are committed to mainstreaming integration.

13.1.3. Integration is not an end in itself but a means to provide more accessible and appropriate care, which makes better use of resources and supports better health and wellbeing outcomes. There has been a cultural shift over recent years with the acceptance that 'we are all in this together.' Councils and their partners recognise that complex challenges of an ageing

population, the needs of working age adults and the growing health inequalities exacerbated by the pandemic can only be addressed through joint working, and intervening earlier and closer to people's homes and communities.

13.1.4. This winter is likely to be one of the most challenging for the NHS and social care, with a backlog of unmet and under-met need, the ongoing impact of the pandemic and growing financial pressures within the NHS and social care. It will take strong leadership at local and national level to maintain a focus on investing in preventative and community-based models of care and support that are vital to integration.

13.2. Impact of Integrated Care Systems (ICSs)

13.2.1. Our intelligence from local authorities on their involvement in ICSs is generally positive. They consider that the joining up of different NHS organisations – and the role of Integrated Care Partnerships in bringing together wider, strategic partnerships – is the way forward for addressing strategic issues. Some ICSs are also committed to supporting and building on existing place-based working driven by Health and Wellbeing Boards.

13.2.2. However, the progress that has been made varies between areas and in some councils there is concern that there might be a shift away from place based joint working as some ICBs seek to operate more at system level. The LGA is committed to working with DHSC and NHSE to develop a peer-led approach to ensuring that all ICSs can learn from those making the most progress. In April 2022 ICBs will take on the statutory responsibilities of CCGs; this is an important milestone, but it is not the end of the journey. Relationships, culture and new collaborative and inclusive ways of working, through the Integrated Care Partnerships and critically at place level, will take time to develop.

13.3. Levers of greater integration

13.3.1. Some of the levers to progress integration across health and social care include:

- giving health and wellbeing boards more responsibility for place-based commissioning
- ensuring that ICSs work closely with existing partnerships and have a clear understanding of the contribution of each level of decision-making and delivery (neighbourhood, place and system)
- government and NHSE fostering a supportive and learning culture in which system leaders have the freedom and flexibility to identify their own priorities and strategies for improving services, improving outcomes and making the most of resources.
- Using assurance and performance management to reinforce expectations of place based, population focused and person-centred working in every system

13.3.2. Given the importance of leadership, the recently announced Government review of health and social care leadership has an important role to play. As rewarding as they can be, leadership positions in the NHS and social care are demanding, challenging and can be draining. We are asking more and more of our leaders at a time of significant challenge and change.

13.3.3. There are excellent leaders in councils, social care providers and the NHS who

are demonstrating the right culture of compassionate, inclusive and collaborative leadership that is needed for today's challenges. The right culture is vital to good quality care and must not be side-lined in the review. Learning from the best to help drive further improvement across the board is central to local government's sector-led improvement mission. The review team must work closely with councils to understand the issues and support the development of strong leadership in the sector.

14. Variation/levelling up: how should the government level up funding of adult social care between different areas and regions of England, given that councils' ability to collect taxes is not connected to the local level of need?

14.1. The reliance on the council tax social care precept has been a poor tax base to fund national entitlements under the 2014 Care Act. It is highly visible locally, but it has no relationship to need, and the money raised has been insufficient to cover increasing costs. On average, a 1 per cent precept has added 1.45 per cent to net adult social care spending, but with a range of between 0.68 per cent and 2.21 per cent. This is why we were particularly disappointed that Government's main approach to tackling social care's core pressures is through the continued use of council tax, the social care precept and long-term efficiencies.

14.2. The LGA does not comment on distributional matters – for every 'winner', there is a 'loser' and it is not our place to comment. What we would say is that the Government currently uses a formula for distributing specific adult social care grants that was designed more than 15 years ago, and with its underlying data last refreshed 9 years ago.

14.3. New formulas were commissioned and then published in 2018 but have never been implemented. The 'Fair Funding Review'(FFR) was supposed to implement a refreshed method to distribute funding within local government, reassessing the differential ability to benefit from council tax increases, but that has been paused since 2019 with no indication on whether or when the work will resume. The FFR was for the entirety of local government and all its services, but within the review the Government proposed putting those 2018 formulas into place for adult social care. However, these formulas are now becoming outdated.

15. Models of provision: should we be moving away from the model of residential care to more home care and, if so, how can Government better support that transition?

15.1. Independent evidence for the ten years up to 2019/20 shows that a transition from residential care to home care is already happening, with a downward trend in the number of people living in CQC registered care homes across the country. The pandemic has accelerated this trend, with the number of people now living in care homes having reduced significantly in the last 18 months, as has the number of people moving into a care home.

15.2. Reports and studies into where and how people want to live when they become older consistently find that people want to remain at home for as long as possible. At the same time, councils are commissioning more home care and support provision to meet this demand.

15.3. To support this transition, we recommend the Government has the following four areas of focus:

15.3.1. National Culture – Support a change in how people view social care and

their own personal circumstances, including challenging assumptions about the eventual need to move into a care home. This should encourage / incentivise people to plan for their future and support people to continue look after loved ones to help them to remain living at home.

15.3.2. Invest in the workforce – The Government needs to take steps to achieve parity of esteem and conditions between the NHS and social care workforce. As a specific example, it should look to create the same terms and conditions for social care staff doing similar roles to those directly employed by the NHS. We will only have the social care sector we want if people are attracted to join and develop within the workforce.

15.3.3. Housing – Support the development of a variety of accommodation, and communities, that support people to live in their own home for as long as possible.

15.3.4. Funding – The steps above will go a long way to creating a national approach to social care, an understanding of the options available to people and how they can best plan for their future needs and the workforce to support people that need it. Alongside this, we crucially need adequate levels of funding to deliver a reformed social care sector.

16. Commissioning: how can we move to a system of commissioning for outcomes?

16.1. Put simply, commissioning for outcomes means taking a person-centred approach to helping people live the life they want, and then putting in place the services to support them to do this.

16.2. A good example of this, is how younger adults with learning disabilities are supported. Up until recently, many learning-disabled people had no option but to be 'cared for', which sometimes meant staying in a long-stay hospital. A 'commissioning for outcomes' approach has shifted the focus of services to put in place the support and accommodation that could help a person get a job, live in their own home and have a family life. This demonstrates the importance of taking a person-centred approach and commissioning services that deliver the best outcomes for each individual.

16.3. Embedding this approach across social care will require a shift in how we view the role of social care, how people interact with social care, and opportunities that may open up around funding. Commission for outcomes is not a new approach but has been happening for a long time and councils are continuing to build on it.

16.4. We suggest that key elements of commissioning in a reformed social care system are:

16.4.1. A person-centred approach to commissioning support, that enables people to lead their best lives

16.4.2. Offering information, advice, control and choice to people to shape their own support wherever possible

16.4.3. Working collaboratively with providers to enable them to deploy this support in a way that empowers people receiving support and those providing it to determine how best to achieve agreed outcomes, and move away from a focus on time and tasks

16.4.4. Working together to ensure that there is a workforce with capacity and skills to achieve this

16.4.5. Creating processes and incentives that enable people to maximise their potential and reach (or regain) as much independence as possible

16.4.6. Working with our NHS and other partners to achieve these objectives and join up support for those drawing on it

17. Regulatory oversight: how is work progressing on adult social care

assurance?

17.1. Assurance of councils' adult social care statutory duties under the Care Act was first put forward in the Government's Health and Social Care White Paper from February this year. Assurance is part of the Government's Health and Social Care Bill, currently making its way through Parliament.

17.2. DHSC, CQC, LGA and ADASS have been working together to develop the assurance framework.

17.3. We recognise the need for more transparency which both gives government more insight into what is happening and creates incentives for local areas to do well on the issues that national oversight is intended to prioritise.

17.4. Government should recognise that reductions in councils' funding led to councils stripping out much of the capacity that used to feed the previous regulatory system. Therefore, any developments around assurance will need to be accompanied by a New Burdens assessment to fairly capture the capacity and resource implications for councils of supporting any changes to the regulatory approach.

17.5. Any assurance process has the potential to highlight shortfalls in services and delivery of the intentions of the Care Act due to resource constraints. Any assessment of a council's adult social care services will need to be contextualised in terms of available resources.

17.6. 'Intervention' will be the sharp end of the process and it is important that this is used by exception and as a last resort. We have had some helpful reassurances from DHSC that this is their guiding principle. There are several issues being worked through and we would be happy to provide the Committee with further updates in the future.

18. What are your views on the speculation around the idea of a National Care Service?

18.1. This idea (or variations of it) has routinely surfaced in recent years. Part of the problem with the idea is that the quoted concept of "health and social care [being] delivered by the same organisation" will mean different things to different people.

Social care already has a strong national dimension – councils' statutory duties are set out in the Care Act; eligibility now operates under a national minimum threshold (as opposed to previously when councils had some discretion over where they set the threshold).

18.2. Social care's local dimension is crucial and helps facilitate a range of local connections to other statutory or third sector services. It also underpins the service with strong local democratic accountability, strengthening links to other relevant services. This 'connector' role is important in pursuing greater personalisation, choice and control.

18.3. Over the last decade, councils have proved more than capable of making tough decisions, innovating, and driving efficiencies, often far beyond the experience of most parts of the health service, which operates with a deficit budget unlike councils, which are legally required to return a balanced budget every year.

18.4. The idea that a more national system would help eradicate unwanted local variation is flawed. Local variations in the availability of cancer drugs, dental and IVF treatments, and the huge variation in eligibility for Continuing Healthcare, demonstrate that national systems do not always result in a standardised offer.

18.5. More generally - and recognising this is an over-simplification - health treats people when they are sick and social care supports people to live independent lives. If, under the most radical of the speculated options, the NHS took control of social care, there would be a real risk of over-medicalising care and support.

18.6. Any option would also constitute a major reorganisation, which would present significant challenges for the sector as it continues to grapple with the longer-term consequences of COVID.

November 2021