**AGENDA**

**RURAL SOCIAL CARE AND HEALTH GROUP**

**Venue:- LGA, Smith Square, London**

**Date: Monday 9th April 2018**
**Time: 11.00 a.m. to 12.00 p.m.**

**ALL NOMINATED MEMBERS AND OFFICERS OF RSN ARE INVITED TO ATTEND THIS MEETING.**

1. **Apologies for Absence**

2. **Minutes of the last Rural Social Care & Health Group – 20th November 2017**
   (Appendix A)

3. **LONG TERM FUNDING OF ADULT SOCIAL CARE INQUIRY**
   (a) To discuss the RSN's response to the Call for Evidence issued by the Heath and Communities and Local Government Select Committees (Appendix B)

   (b) To consider what else the Group might want to prepare ahead of the promised government Green Paper to be published later this year.

4. **To consider the results of the RSN internal consultation as to priorities for the Group** (Attachment C)

5. **Regional Meetings/Seminars**
   To receive and consider the minutes of the first two Regional Meetings/Seminars (Please see attachments C & D on Rural Assembly Sub SIG Agenda)

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6. **Any Other Business**

   The next meeting of this Group is scheduled for 12th November 2018.

Local Government Association

# Note of 1st meeting of Rural Social Care and Health Group

**Date:** Monday 20 November 2017, 11.30am – 12.45pm

**Venue:** City of Westminster Archives Centre, 10 St Ann's Street, London SWiP 2DE

**Attendance**

Attendance at this meeting is included within the list at **Appendix A** of the RSN Rural SIG AGM note.

**Item Decisions and actions**

The unanimous feeling of the meeting was one of great support for the creation of this new Group which it was agreed would cover the issues of Social care, Health, Public Health and Well-Being.

It was noted that future agendas for this group, in addition to going to nominated Councillors and Portfolio Holders/Lead Members, would also go out to Directors of Public Health and Chairs of Health & Well-Being Boards

There followed a general discussion on the current major issues relating to the service areas concerned and examples of initiatives to address them. The following points were made:

- The demographics were working against Rural Authorities. For them the consequential problems were increasing twice as fast as in many urban areas.
- The additional Council Tax increase allowed for Adult Social Care was only covering about half of the growth rate of the budget. In Devon the increase had been £8m of which the increase in Council Tax had only covered £4m.
- In terms of Life Expectancy there was a marked difference (15 years) between the South and North Devon average life spans demonstrating the impact of poverty and resulting poor health.
- Serious concerns were expressed about recruitment and retention issues across the whole NHS in rural areas and in the rural social care sector.
- Individual Councils were starting their own initiatives:
    - West Linsey had set up a Health Commission.
    - A Council Loneliness scheme relating to cooking tips for beavered residents had been set in South Norfolk.
    - The Yealm Estuary (Devon) initiative involving a number of parishes on a Dementia assistance scheme.
    - Parochial initiatives around Fuel Poverty.

**It was suggested that RSN could help considerably by setting up an Information Exchange area on RSNOnline**

- All members agreed that the catchment area applying to rural residents to get medical assistance had widened markedly while transport options had fallen back.

- There was concern that failure to have checks and present with first ill health systems because of access problems would cost of the country far bigger sums of money than any savings in the long term.
- Rural Dementia was expressed as being “the equivalent of the plague of recent years”.
- Loneliness was a recognised and now accepted pathway to Dementia- it was in the national financial interest that loneliness was tackled.
- Some members felt the number of food banks in their areas had trebled.
- Many members felt Rural Fuel Poverty with its resultant health difficulties was considered to have increased significantly in their areas.
- Many members reported that Care Homes were closing in rural areas just as the need was increasing – the sustainability of the care market in rural areas was a real concern.
- The difficulty of getting people to deliver Social Care was detailed by many authorities. This it was believed was because carers had to travel long distances – unpaid in terms of the time involved - to do their job in rural areas and pay was generally low. Other seasonal minimum wage employment was an attractive alternative in the summer months.
- It was considered by some authorities that care assistances importance needed be more recognised by proper career structuring and the ability to get socially rewarded qualifications.
- Modern Technology (robotics, ‘health monitoring in the home’ etc.) could assist in the longer term in some areas but obviously they were dependent on universal super-fast broadband and mobile connectivity links that just weren’t there currently.
- That failure to achieve universal broadband stopped people being able to look things up - a clear way of avoiding loneliness.
- Digital health was likely to have increasing importance and might be a weapon against remoteness but the lack of universal broadband would prevent that throughout rural areas
- The withdrawal of bus services was creating really large social problems for many.
- There was real concern about rural ambulance services that seemed to be getting even poorer.
- Some Councillors emphasised that the difficulties did just lie with an older aging population- there was concern about the psychological health of young people in rural areas as they saw their educational opportunities being closed down by access to their preferred courses becoming impossible and the closing of youth facilities. There were also great concerns about the costs and services able to be provided in respect of Looked After Children and those with Special Needs.
- The need for more preventative measures was stressed rather than the focus on treating ill health. Despite the obvious benefits from such an approach government funding for Public Health was constantly being reduced
- There were issues to consider regarding How we tackle innovation, the sharing of best practice, the need for funding to be directed to “place” not service silos and the operation of the Better Care Fund

**The meeting continued to feel that RSN could play a very full role here, particularly in terms of recording and cataloguing of perceived problems which were becoming increasingly evident.**

**Members felt there would be a need to choose carefully over the areas where it was felt RSN could work to the greatest advantage. Although the debate had been wide ranging, important choices would have to be made to prioritise activity. It was agreed that the RSN would send out a survey questionnaire to ascertain member's suggested top priorities. This could also be used to get good practice examples from member authorities**

One suggestion was that a system of specific task orientated working groups needed to be created to supplement the two meetings a year that would work in this area.

It was agreed that the meeting in June would receive a full report from the officers and the Executive which would set out suggestions for taking forward rural work of the Social Care and Health Group.

**NEW NATIONAL CENTRE FOR RURAL HEALTH AND CARE**

RURAL SERVICES NETWORK

**Attachment B**

**LONG TERM FUNDING OF ADULT SOCIAL CARE INQUIRY: JOINT INQUIRY BY THE COMMUNITIES AND LOCAL GOVERNMENT AND HEALTH SELECT COMMITTEES**

## 1.0. INTRODUCTION

The Rural Services Network is pleased to have the opportunity to submit written evidence to the Call for Evidence relating to the above Joint Inquiry.

**This response focuses on the question "How to fund social care sustainably for the long term (beyond 2020) bearing in mind in particular the interdependence of health and social care systems"**

The Rural Services Network is the national champion for rural service provision, ensuring that rural people across England have a strong voice. It argues for a fair deal for rural communities, to maintain their social and economic viability for the benefit of the nation as a whole. The membership of RSN comprises 154 local authorities (county, unitary, district and borough councils) and over 100 other service providers from the public and private sector (e.g. fire and rescue authorities, housing associations and bus operators) and a range of national interest groups

## 1.0 SUMMARY OF VIEWS

**In Summary the views of the Rural Services Network are: -**

- **The present system of funding both Adult and Children's Social Care Services is unsustainable and, moreover, is very unfair and inequitable for providers operating across rural areas (and the Council Tax payers in those areas) when compared to their urban counterparts.**
- **Social Care is a national issue – and at present in crisis nationally. It should be 100% funded by central government in terms of a national core level(s) of service available (at the same cost if personal financial contributions are to be required) to all, irrespective of where they live. However, the Service should continue to be delivered at the present level of County/Unitary local authorities with sufficient discretion to determine how that core level(s) of services should be provided in their local context. Council Tax is not a suitable taxation vehicle for demand responsive services and produces a postcode lottery of supply which is able to be funded**
- **Council Tax should only be used to fund any exercise of discretion by the local authority to provide a service above the national core level(s)**
- **It costs substantially more to provide Adult (and Children's) Social Care in rural areas than it does in urban and there is higher demand for services. As a statutory duty the services have to be prioritised and as a consequence other budgets - rural transport support, for example – are being cut significantly.**
- **Formulae to fund the delivery of the national core levels of service must fully reflect the different costs of delivery imposed by the geographical conditions and population dispersal patterns of each area. Such costs inevitably impose service**

**delivery impacts on rural councils, which are compounded by issues such as poor economies of scale and poorer external markets for delivery.**

- **The population of rural England is much older than that of urban areas and is ageing faster. The problems of rural isolation and distance makes it harder and more expensive) to deliver services to dispersed populations.**
- **A future system of dealing with care needs must address, and properly fund, the "prevention" services" provided by County and Unitary Councils through Public Health funding and also those services provided by District/Borough Councils which are aimed at enabling people to live healthily and safely in their own homes (if necessary with support) as long as possible.**

We set out below our evidence as to the inequalities in funding currently faced by rural councils and their council tax payers as well as other core data relevant to the issues being considered by the Joint Inquiry.

## 3.0 KEY EVIDENCE AND DATA

### (a) The Demographics

- 23% of England's rural population (of 9.3 million – 19% of the population) are aged over 65 compared to 16% in urban areas.
- In the ten years between 2005 and 2015 the number of people living in rural areas and aged over 85 years increased by 36.4%. The comparative figure for urban areas was 27.6%
- The ONS predictions for local authorities shows that by 2039 1 in 3 rural residents will be aged 65+ and of those 11% (currently 6%) will be aged 80+ (See Appendix A).
- It is the population aged over 85% where there is the most likely need for Social Care Support together with more complex, more intense and wider ranging (and hence more expensive) support.

### (b) Inequities in the current system affecting Rural Service Providers and Rural Council Tax Payers

- In respect of Local Government Services generally, there has been historic, chronic underfunding of rural areas by successive governments, despite the acknowledged higher cost of providing services to remote communities and the lower than average incomes of people living in them. This basic inequality is in danger of becoming still greater.

- As a consequence of the fact that rural areas have received substantially less government funding per head of population for their local government services compared to urban areas rural local authorities had increasingly to rely more heavily on Council Tax income than their urban counterparts, whilst still struggling with considerably lower Spending Power overall. This has inevitably impacted on the level and range of services they could provide.

- Thus, rural residents, who on average earn less than their urban counterparts, pay more in Council Tax but get less government grant and receive fewer services which cost those residents more to access. In addition, according to recent research, rural residents pay some £3000 more per annum for 'essentials' than their urban counterparts.

- Whilst increased funding for Adult Social Care is much needed, the amounts provided through the Final Settlement for 2019/20 – despite having been increased above the Provisional Settlement figures - will, once again, hardly scratch the surface of the underlying funding crisis that these services face across England. Furthermore, the fact that much of this increase has to come from Council Tax is both wrong and blatantly unfair to rural residents. The Council Tax precept for Adult Social Care is only covering, at most, 50% of the required budget growth due to demand and increased expenditure on things such as the National Living Wage.

- The Government's introduction of the Improved Better Care Fund, whilst insufficient to meet the Adult Social Care crisis is, in principle, a step in the right direction. However, yet again the Government's policy has built inequity into the system. The inclusion of the Council Tax flexibility in the IBCF calculations means that, once more, rural residents are forced to contribute more in council tax levies to fund pressures which the Government is funding in urban areas. The use of the Social Care Relative Needs Formula, frozen in 2013/14, in the Better Care Fund means that social care authorities serving rural areas are not being recompensed for the significant growth in their older population -or indeed the greater costs of meeting those needs. Moreover, much of the funding raised through the social care precept has been absorbed by the introduction of, and increases in, the National Living Wage

- **Taking these things together, it is not surprising that, yet again, more government grant per head goes to urban areas per capita. In 2019/20, the average predominantly urban resident will attract £37.74 per head in Improved Better Care Funding, £8.20 per head more than rural residents per head (of £29.54). In 2017/18 Adult Social Care Core Funding is met by Council Tax to the tune of 76% in rural areas compared to just 53% in urban.**

- There is no relationship between the numbers of people requiring social care and either Council Tax or Business Rates. Growth in business rates or council tax income is in no way

correlated to the service needs of care services It is obvious that the rising costs of caring for the growing elderly population cannot be met by local taxation and must be funded per capita by central government. In rural areas there are significantly more residents aged 65+, fewer businesses required to pay business rates and Council Tax levels are already much higher than in urban areas. Thus, there is created a 'perfect storm' of rising costs and limited income in the rural areas across England.

- In 2015/16, Settlement Funding Assessment (SFA) per head of population for all services in predominantly urban areas at circa £428 was already some 43% higher than in predominantly rural areas of circa £299. By the end of the settlement period, SFA per head in predominantly urban areas will reduce by just 30.79% compared to a reduction of 41.25% in predominantly rural areas. The cost pressures in Social Care Services mean that County and Unitary Councils serving rural areas are having to cut other budgets to the detriment of the well-being of rural residents and businesses
- Council Tax per head, in 2018/19 is reflected in the Final Settlement at £541.46 for Predominantly Rural Areas compared to £450.58 in Predominantly Urban Areas. The gap, at circa £91 per head, is inexcusable.

- The 2018/19 Settlement re-enforces the view that there appears to be a conscious policy decision by the Government that in rural areas Spending Power will be increasingly funded by council - taxpayers. In other words, the Government is content for people in rural areas to pay more Council Tax from lower incomes and yet receive fewer services than their urban counterparts**.** This is manifestly unreasonable and totally inequitable

- The table below shows the relative gearing between Government Funded Spending Power and Council Tax between predominantly rural and predominantly urban areas over the four-year settlement period as a result of the inequitable changes to the calculation of Revenue Support Grant cuts.

| **Percentage of Spending Power funded by Council Tax over the four-year settlement period** | | | | | |
|---|---|---|---|---|---|
| | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
| Predominantly Rural | 58% | 62% | 66% | 69% | 71% |
| Predominantly Urban | 45% | 49% | 53% | 55% | 57% |

- The Government is placing unacceptable pressure on the council tax payers in rural areas. Band D council tax is higher than in many other parts of the country, particularly Inner London. By allowing all areas the same percentage increase in Band D, including in respect of the Adult Social Care Precept, the divergence will only grow over time, placing increasingly greater pressure on residents in county areas.

- The role of preventative services in respect of adult social care is not formally recognised by government and district councils are not funded for public health. With increasing

pressures on district council budgets, there remains uncertainty as to how public health interventions delivered at a local level will be funded in the future.

- The reduction in New Homes Bonus Funding through the introduction of the 0.4% baseline removed £70 million of funding from district councils in order to fund adult social care authorities. The funding crisis for social care is significant; however, future solutions must avoid repeating this approach of recycling existing funding. This approach completely overlooked the importance of housing services to health and hindered the ability for districts to deliver preventative services and reduce demand on the social care system.

## (c) Examples of Higher Demand for Services in Rural Areas

(Taken from HHS Digital, Summary figures regarding Adult Social Care Activity and Finance 2016-17)

- Number of requests for support received from new clients (18 and over)
- Predominantly Rural = 4615 requests per 100,000 resident population in age group
- 16.5% greater than Predominantly Urban (3960 requests per 100,000)

- Admissions to long term nursing or residential care
- Predominantly Rural = 141 admissions per 100,000 resident population
- 31.0% greater than Predominantly Urban (107 admissions per 100,000)

- Support provided to carers during the year
- Predominantly Rural = 753 cases per 100,000 resident population
- 15.9% greater than Predominantly Urban (650 cases per 100,000)

- Number of requests for support received from clients moving from children's social care into potential support for adults
- Predominantly Rural = 18 requests per 100,000 resident population in age group
- 55.0% greater than Predominantly Urban (12 requests per 100,000)

- Gross Current Expenditure on Long Term Support (support provided with the intention of maintaining quality of life for an individual on an ongoing basis)
- Predominantly Rural = £261 per head of resident population
- 7.1% greater than Predominantly Urban (£244 per head)

- Total number of episodes of short term support to maximise independence completed for existing clients aged 18 to 64
- Predominantly Rural = 18 episodes per 100,000 resident population in age group
- 45.5% greater than Predominantly Urban (12 episodes per 100,000)

- Gross Current Expenditure for Short Term Care to Maximise Independence
- Predominantly Rural = £719 per 100 adults
- 9.1% greater than Predominantly Urban (£659 per 100 adults)

- Number of Clients aged 18-64 Accessing Long Term Support for Social Isolation/Other
- Predominantly Rural = 23 per 100,000 resident population in age group
- 81.7% greater than Predominantly Urban (13 clients per 100,000)

- Number of Clients aged 64 and over Accessing Long Term Support for Social Isolation/Other
- Predominantly Rural = 92 per 100,000 resident population in age group
- 10.1% greater than Predominantly Urban (83 clients per 100,000)

- Gross Current Expenditure on Support for Social Isolation/Other
- Predominantly Rural = £210,982 per 100,000 adult population
- 20.0% greater than Predominantly Urban (£175,877 per 100,000 adult population)

- Average weighted standard hourly rate for external provision of home care (unit costs)
- Predominantly Rural = £16.43 per hour
- 11.0% greater than Predominantly Urban (£14.81)

- Number and Value of Deferred Payment Agreements
- Predominantly Rural = 12.4 DPAs per 100,000 resident population, £342,918 per 100,000 resident population
- 10.4% and 18.8% respectively, greater than Predominantly Urban (11.2 DPAs, £288,620 per 100,000 resident population)

## (d) Prevention Services

- Firstly, looking at the Public Health Grant Allocations we see –

**For the year 2018/19,**

| | |
|---|---|
| Predominantly Rural (PR) | £42.97 per head |
| Predominantly Urban (PU) | £66.91 per head (55.7% greater than PR) |

**Attachment B**

**Indicative allocation for year 2019/20,**

| | |
|---|---|
| PR | £41.61 per head |
| PU | £64.63 per head (55.3% greater than PR) |

- With adult social care at a precipice, government must recognise and adequately resource prevention services to reduce demand on primary care. At present, the social care crisis is being dealt with through piecemeal responses, with funding diverted between government priorities to deliver short term fixes rather than addressing complex underlying issues.

- To provide a long-term solution to social care it is necessary for any new arrangements to provide separate funding streams and acknowledge the importance of prevention, which is fundamental to driving down the currently unsustainable costs of adult social care and improving people's lives over the long term.

- Housing authorities provide a whole range of services critical to the wider health agenda. Prevention services include leisure and recreational services, tackling homelessness, providing debt advice, supporting troubled families, joined up help services, improving air quality and improving housing as well as services provided through Public Health funding. A recent report by the CLG Select Committee conclude that older people need greater help with housing to enable them to live independently. Both Stephen Dorrell, the Chairman of the NHS Federation and Duncan Selbie, the Chairman of Public Health England in recent comments have recognise the important role of housing in reducing demand for care support.

- These services reduce the burden on adult social care and the NHS, they help prevent, or at least delay, residents needing to access services both in the short and long term. The needs of an ageing demographic mean it is more important than ever that funding is spent keeping people well and safe in their own homes and empowered to care for themselves independently. These service areas significantly impact the wider determinants of health and are crucial to addressing the increased pressure on primary care.

- The part that such services play in health is well evidenced and recognised within the sector. We understand that the District Councils Network (DCN), as part of its submission to this Joint Inquiry, are referencing both a Kings Fund report on the district council contribution to public health and also a recent NHS England press release both of which evidence the key preventative role.

- The DCN has called for the ability to raise a 2% precept on council tax which could raise up to £25 million for district councils to invest in public health**.** For every £1 spent on prevention, up to £70 worth of savings on health spending can be made in the long-term - according to the Kings Fund Report. This would mean additional funding from the precept could save over £1.5 billion over the long term.

## 4. OTHER ISSUES RELEVANT IN THE RURAL CONTEXT

- Despite the massive investment made by rural councils to make super-fast broadband available in their areas (a cost which their urban counterparts have not had to face) there is still not anything like 100% coverage. The deployment of modern technology to assist service delivery is, therefore, not an option at present in many parts of rural England - thus the cost savings from Assistive Technology cannot be realised. Realistically, rural areas are always going to fall behind urban areas in the roll-out of enhanced technology by the market.

- The sustainability of the Care Home and the Care Provider Sectors in rural areas is a real concern. Many rural councils are facing problems with care contracts being "handed-back". Recruitment and retention of staff is also a growing. Many providers lose staff during the summer time as they take up other seasonal employment opportunities even where they are receiving the National Living Wage levels. Both sectors need support to offer lasting career opportunities and the ability to gain socially rewarded qualifications.

- Two recent authoritative studies of recruitment and retention problems within adult social care by the National Audit Office and the Social Care Workforce Research Unit both concluded the sector was facing a staffing crisis exacerbated by continued uncertainty over financial sustainability.

- Ever reducing rural transport is reported to be leading to some older people not seeking medical support early enough potentially leading to more severe health conditions and earlier need for support.

- If an individual has, say, £100,000 in the value of their assets and are therefore self-funders the value of those assets will be depleted faster in rural areas where care costs ae higher. This in tern means that they will become 100% funded by the local authority much earlier than someone with the same £100,000 in an urban area.

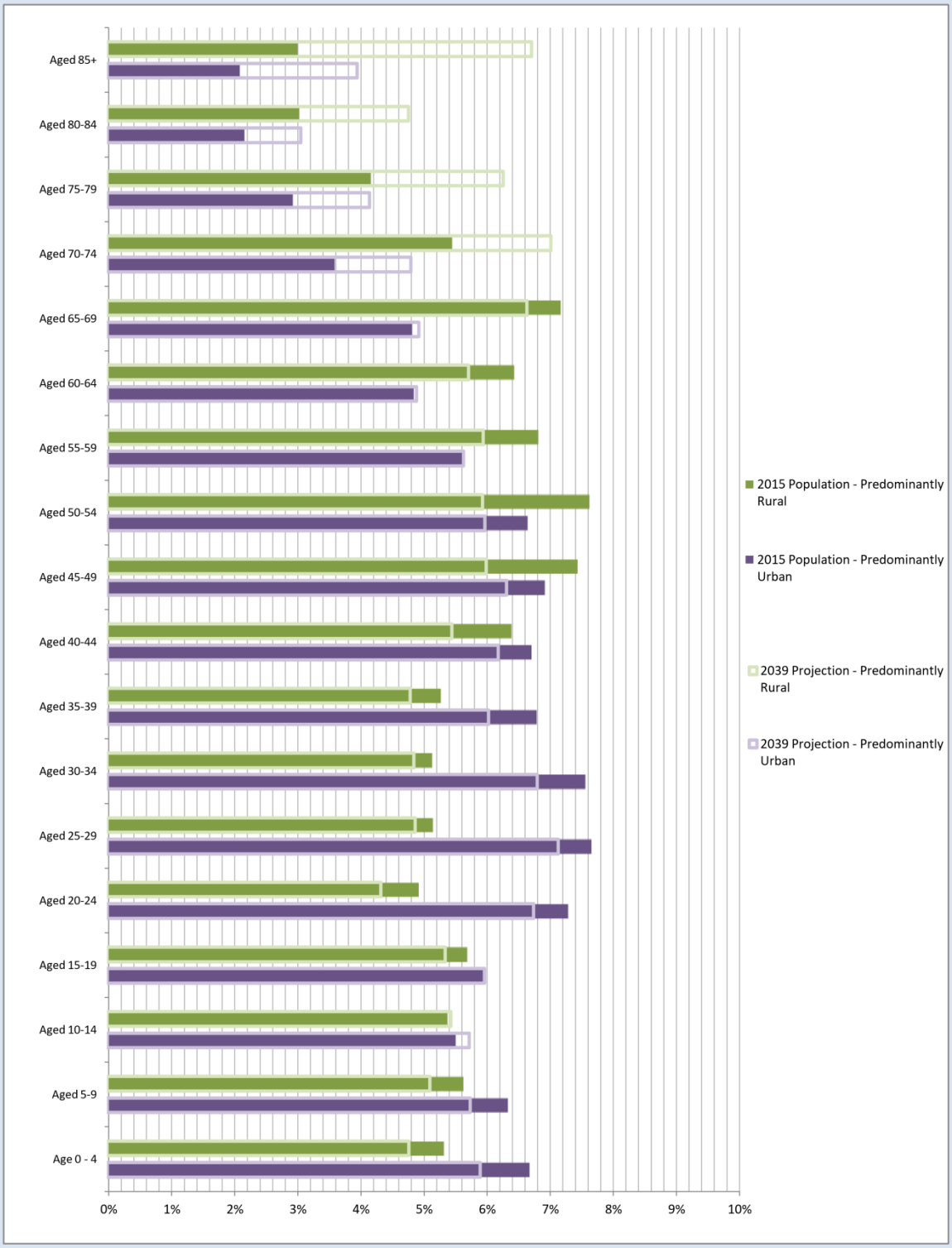
- In a joint report issued last year the Local Government Association and Public Health England considered a whole host of issues impacting on "Health and Wellbeing in Rural Areas". That report commented –
  - "But for a number of years, there has been a growing realisation by national and local government that broad-brush indicators measuring the largely positive health, wealth

and wellbeing in rural area can mask small pockets of significant deprivation and poor health outcomes"

- "Both sparsity and rurality appear to affect poverty levels and consequently the health of people in rural areas".
- "One of the difficulties in writing this document is the absence of statistical information on health outcomes in rural areas as they are usually sub-divisions of the larger areas for which statistics are available"
- "Financial poverty in rural areas is also highly concentrated amongst older people, with around one-quarter of those in poverty in pensioner households"
- "Along with reductions in central government grant to local authorities, expenditure on adult social care services has declined and this has led to provision focusing on those assessed as having either critical or substantial needs"
- While the 'personal budgets' awarded to people in rural areas are lower, charges for social care are, on average, higher in rural areas, significantly so with respect to home care charges"
- "Reductions in resources for social care are compounded by the fact that population sparsity leads to higher delivery costs and makes it more difficult for commercial providers to keep their staff"
- "overall, around one sixth of areas with the worse health and deprivation indicators are located in rural or significantly rural areas"
- "It cannot be assumed that the health and social care needs amongst older people are or will be evident, Research for Defra in 2013 identified evidence of significant unmet needs from health services but found that these were often hidden"
- Service users themselves tend not to identify unmet need, and are also reluctant to discuss challenges around getting the health care that they require. Also, many older residents do not seek out preventative health care or even acute treatment, and in some cases avoid seeking care even in moments of emergency and health crisis"

## APPENDIX A

**Proportion of population in specified age brackets by rural/urban classification**




*(ONS population estimates 2015 / ONS 2014-based population projections for local authorities)*

# Priority List for Health and Social Care Group

At the first meeting of the Health and Social Care Group held in November 2017, a number of areas in relation to rural health and social care were discussed. It was decided to carry out a survey of members to assist the group to choose carefully over the areas where it was felt RSN could work to the greatest advantage and prioritise activity.

The survey has been sent to all that were invited to the meeting in November and the following information has been gathered.

Respondents were asked to select their top 3 areas from a wide list of areas. The results have meant that one area came out top with three additional areas sharing the second place spot.

- Need for preventative measures rather than focusing on ill health – Public health funding is reducing
- Focus on early intervention – this can be difficult if people don't present for support early due to access and transport problems
- Sustainability of the care market in rural areas
- Demographics – the increasingly ageing population

Reasons for choosing these as the areas for work to focus included:

*Early intervention and preventative measures are fundamental in helping to reduce a higher cost re hospital stay and greater infirmity. For this, the right preventative measures need to be in place, and the right support available when needed that will enable people to remain independent. Social integration and support networks are a fundamental requirement for a reasonable quality of life but are becoming increasingly to maintain.*
*There is a role for the third sector, town and parish councils and other elements of the public sector. Public health funding is not decreasing at the rate that funding for social care is decreasing, as it remains ring-fenced. There is an opportunity for Public Health to play a more fundamental role in preventing rural isolation and deprivation, as this is a key determinant of health.*
*The social care market has a significant problem with recruitment and retention of staff, especially in rural areas. Sustainability of the care market may therefore depend on the development of alternative care and support systems, ones which provide more attractive jobs.*

Respondents were also asked to provide Good Practice examples of work in their rural areas. These will all be fed back to the Rural Health & Social Care Group but included:

- https://www.connecttosupporthampshire.org.uk/home
- Social prescribing is developing - Haverhill, Leiston Community Partnership which includes DCLG funded social prescribing (http://www.eastsuffolk.gov.uk/news/leiston-to-benefit-from-social-prescribing-pilot/)
- National Centre for Rural Health and Care Business Plan