INTERIM REPORT OF THE RURAL SERVICES ALL PARTY PARLIAMENTARY GROUP (APPG) INQUIRY INTO THE LONG -TERM FUNDING OF ADULT SOCIAL CARE IN THE RURAL CONTEXT

1.0 INTRODUCTION

1.1 The Rural Services APPG has for some months been carrying out an Inquiry into the future funding of Adult Social Care in the rural context. The Inquiry was limited to England.

1.2 The Inquiry has been conducted to enable the APPG to submit evidence to, and to respond to the specific issues contained in, the Government's Proposed Green Paper on the subject to be published later in 2018.

1.3 The APPG's work on this subject is on-going and this report should, therefore, be regarded as an Interim Report.

1.4 The APPG has not limited itself to issues directly related to the financing of Adult Social Care. It has also considered matters such as staffing and skills, resource distribution, the challenges to the sustainability of the care market in rural areas and has sought examples of best practice.

2.0 BACKGROUND

2.1 The Seven Guiding Principles for the Proposed Green Paper

In March 2018 the then Minister responsible for Health and Social Care Secretary, set out seven principles, which will "guide the Government's thinking ahead of the social care green paper". These are:

- quality and safety embedded in service provision
- whole-person, integrated care with the NHS and social care systems operating as one
- the highest possible control given to those receiving support
- a valued workforce
- better practical support for families and carers
- a sustainable funding model for social care supported by a diverse, vibrant and stable market
- greater security for all – for those born or developing a care need early in life and for those entering old age who do not know what their future care needs may be.

As far as practicable the APPG is presenting its findings against these Seven Guiding Principles as set out in Section 4 of this Report. The Rural Context is explored in Section 5.0 of this Report.

Resource Distributional Issues are not referred to in the 7 Guiding Principles but the APPG's Analysis and Views on that subject are set out in Part 1 of this Report (with the evidence in that regard set out in Appendix A).

2.1 In Part 1 of this Interim Report we set out our recommendations from our work to date. In Part 2 we set out the conduct of the APPG's Inquiry and its findings from which our recommendations flow

PART 1: RECOMMENDATIONS

A. OVER-ARCHING RECOMMENDATIONS

1.The present system of funding both Adult and Children's Social Care Services needs to be changed urgently and ahead of new legislation flowing from the Green Paper's wider considerations. The present system 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. There needs to be a substantial re -balancing to those areas which have the oldest populations in both the 65+ and 85+ age categories
2. Social Care is a national issue – and at present is 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. 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.
3. 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).
4. 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 in APPENDIX A 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.

B RESOURCE DISTRIBUTIONAL ISSUE RECOMMENDATIONS

5. The way in which resources from taxation are distributed/ re-distributed and the proportion of the total costs to be funded by local Council Tax payers must be fair across both urban and rural areas and fully reflect the costs of providing the care needed in different geographical contexts. This demonstrably is not the case at present as we set out in Appendix A. This applies to government distribution/re-distribution of funding for both Adult and Children's Care and Pubic Health duties

6. In taking account of the amount to be funded by local council tax payers a notional amount of council tax should be applied across all councils. This would remove any perverse incentives for Councils to keep council tax low to generate more government grant.
7. 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 broadband and mobile phone connectivity, lack of economies of scale and poorer external markets for delivery.
8. It should not be the case that because 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 - the necessary prioritisation of these (statutory) services, comes at the expense of other services such as rural transport support, for example.

C. WORKFORCE PLANNING RECOMMENDATIONS
9. Introducing 'rural proofing **into health service planning and delivery in rural areas is strongly recommended. A good way of doing this would be to *introduce an additional 'spatial' component to Health Education England's (HEE) workforce planning STAR tool*.**
10.There should be investment into disseminating good practice **and this could include developing *centres of excellence*** **in specific aspects of rural health and care delivery.**
11. A more segmented approach to workforce recruitment, retention and development **should be developed based on a better understanding of the demographics of rural areas (e.g. age cohorts and sub-groups of the current and future workforce).**
12. There should be a detailed mapping of programmes and initiatives that have funded innovative approaches to workforce development **in the past 15 years and identify projects located in rural areas.**

PART 2: THE CONDUCT OF THE APPG's INQUIRY AND ITS FINDINGS

3.0 RESEARCH FOR THE APPG

On behalf of the APPG its Secretariat for the purpose of this Inquiry (The Rural Services Network (RSN) in partnership with the new National Centre for Rural Health and Care) commissioned a survey of rural upper tier authorities in RSN membership to ascertain their views and experiences

of the issues trailed in the build up to the Green Paper on Adult Social Care. The survey also asked a number of additional contextual questions.

On receipt of replies to the initial survey some additional questions were subsequently put to the respondents. The results of these two surveys are set out below under the relevant guiding principle together with details from presentations made to the APPG and evidence from literature review and other research conducted for, or on behalf of the APPG.

12 responses were received from a good cross section of RSN members. They were:

- Cornwall
- Hampshire
- Herefordshire
- Lincolnshire
- North Yorkshire
- Northumberland
- Nottinghamshire
- Rutland
- Shropshire
- Somerset
- West Sussex
- Worcestershire

4.0 THE DELIVERABILITIES AND CHALLENGES OF THE 7 PRINCIPLES IN THE RURAL CONTEXT

4.1 GUIDING PRINCIPLE 1: Quality and Safety Embedded in Service Provision

- A lack of transport options and the distance between individuals needing care in rural settings were highlighted as the main challenges in this context.
- 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
- Other major risk factors were cited as a lack of workforce choices and limited funds to underpin the cost of an increasingly expensive service. There was a recognition amongst respondents that they needed to meet a rural premium cost in terms of attracting a quality workforce.
- Supporting sustainability and choice were referenced as key challenges exacerbated by rurality. The challenge of facilitating good quality provision for self-funders was acknowledged as a general principle first and then as an issue exacerbated by rurality. Contractual approaches to setting quality and safety standards and quality assurance approaches were cited as factors underpinning quality and safety.

- Particular “pinch points” referenced by respondents to the APPG’s survey were:

- **Increased travel**. Rural areas by nature of their population have lower numbers of customers requiring care than in built-up urban areas and customers are geographically more widely spread.
- **Costs to ensure viable and sustainable services**. With increased travel and consequently less direct time spent with customers, this means lower income for providers and higher costs.

4.2 GUIDING PRINCIPLE 2: Whole Person Integrated Care with the NHS and Social Care Systems Operating as One

- There were some examples of progress but broad unanimity that this was not in place in any of the areas we received feedback from. The complexity of the organisational framework for supporting people was cited as being exacerbated by the physical sparsity of counties such as North Yorkshire and Lincolnshire.
- Poor broadband was referenced as a rural challenge in using IT connectivity to its maximum in addressing the challenge of greater integration.
- 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 in such areas. Realistically, rural areas are always going to fall behind urban areas in the roll-out of enhanced technology by the market.
- Integration in a rural area was identified as being hardest for those with the most complex needs due to the dispersion of specialist providers of services. The difference in terms of funding constraints on each sector was referenced with a view from some areas that the lack of a need for a balanced budget within the NHS side of the equation led to an unbalanced set of expectations amongst providers in terms of the affordability of care.

4.3 GUIDING PRINCIPLE 3: The Highest Possible Control Given to Those Receiving Support

- The personalisation agenda and the provision of direct payments were referenced as a core element of this. A lack of local options in terms of the use of personal budgets was referenced as a challenge in rural settings. Some areas also identified a non-rural specific lack of enthusiasm amongst some individuals to take on the responsibility of personal budgets.
- The principle of taking a person - centred approach to planning provision was referenced along with the caveat that in rural settings limited provision and choice made this more difficult. Managing increasing expectations of choice and opportunity for clients was referenced as being more challenging because of the limits on what is available in rural areas.
- The scope to increase personal support by developing volunteer - based services in rural settings was identified – although “volunteer overload” in rural areas is acknowledged.

4.4 GUIDING PRINCIPLE 4: A Valued Workforce

- The environment within which the workforce operate was cited as a common challenge, particularly in respect of the housing options available to low paid workers in rural settings.
- Recruitment and retention of staff is also a growing problem. 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 Health and Care 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.
- The role of good quality and well adapted housing for older people were cited as factors which ameliorated the pressure on care workers in relation to the intensity of personal support required by clients.
- The need to provide wage enhancements particularly in relation to retaining a stable workforce was referenced as a key challenge in rural settings. Working on a third -party basis with the intermediary organisations providing carers was also identified as a challenge.
- Setting minimum expectations, particularly in terms of workforce training and development was referenced as a key challenge. An ongoing lack of recognition of the value of adult social care as a profession was identified as a significant issue.
- A recent report published by the National Centre for Rural Health and Care applied a rural lens to the workforce challenges facing the NHS and social care in England in recognition that *securing the supply of staff* that the health and care system needs to deliver high quality care now and in the future is crucial.

  This report entitled 'Rural Workforce Issues', sets out a number of findings, conclusions and recommendations which are detailed below.

'Rural Workforce Issues' Findings

- In summary, the report found that the main ***challenges*** facing rural areas face in securing the supply of staff that the health and care service needs are that:

  1. "Rural areas are characterised by disproportionate out-migration of young adults and immigration of families and older adults.
  2. This means that the population is older than averag***e*** in rural areas - this has implications for demand for health and care services and for labour supply
  3. Relatively high employment rates and low rates of unemployment and economic inactivity mean that the labour market in rural areas is relatively tight
  4. There are fewer NHS staff per head in rural areas than in urban areas.
  5. A rural component in workforce planning is lacking.
  6. The universalism at the heart of the NHS can have negative implications for provision of adequate, but different, services in rural areas and also means that rural residents can be reluctant to accept that some services cannot be provided locally.

7. The conventional service delivery model is one of a pyramid of services with fully-staffed specialist services in central (generally major urban) locations – which are particularly attractive to workers who wish to specialise and advance their careers.
8. Rural residents need access to general services locally and to specialist services in central locations to provide best health and care outcomes.
9. Examples of innovation and good practice are not routinely mapped and analysed, so hindering sharing and learning across areas.

- The main ***opportunities*** for securing workforce supply and maximising impact identified in the report are

1. Realising the status and attractiveness of the NHS as a large employer in rural areas (especially in areas where there are few other large employers)
2. This means highlighting the varied job roles and opportunities for career development available and that rural areas are attractive locations for clinical staff with generalist skills.
3. This means developing 'centres of excellence' in particular specialities or ways of working in rural areas that are attractive to workers.
4. This requires developing innovative solutions to service delivery and recruitment, retention and workforce development challenges.
5. This may provide opportunities for people who need or want a 'second chance' – perhaps because the educational system has failed them, or because they want to change direction; their 'life experiences' should be seen as an asset.
6. Finding new ways to inspire young people about possible job roles and careers in health and care.
7. Drawing on the voluntary and community sector, including local groups, to play a role in the design and delivery of services, as well as achieving good health outcomes for rural residents.
8. Promoting local solutions can foster prevention and early intervention and enhance service delivery.
9. Using technology so face-to-face staff resources are concentrated where they are most effective.

- The report suggests that inherent in these challenges and opportunities are a number of *trade-offs* concerning:

- Achieving an optimal balance from staff and service user perspectives on centralisation versus localisation of services.
- Providing the flexibility that health and care workers increasingly desire while achieving required safety standards in health and care delivery.
- Attaining an appropriate mix of specialist and expert generalist staff in situ in rural areas to provide high quality health and care services for residents.
- Appropriate use of technology and face-to-face provision of health and care services.

- **'Rural Workforce Issues' Conclusions:**

  - There is *systemic lack of 'thinking rurally' in workforce planning in health and care*. This poses challenges both for staff development and for access to health services in rural areas. It points to rural disadvantage that remains unacknowledged.
  - Sparser and smaller populations, higher employment rates, lower unemployment rates, an older population and relatively fewer younger people *pose challenges for recruitment, retention and workforce development in rural areas*.
  - Despite having common features *rural areas are diverse*. There is increasing awareness and recognition amongst policy makers and the general public that 'place matters' in terms of healthy life expectancy. The importance of *sensitivity to local circumstances* also needs to be considered in workforce planning in rural areas.
  - Establishing and, as far as possible, fostering consensus on what *health and care service delivery should look like in rural (and urban) areas,* and what staffing models are most appropriate to achieve this lies at the heart of workforce supply and development issues.
  - *Urban bias* is apparent in the application of the universal service and standards approach of the NHS. This tends to further disadvantage rural areas which can face enhanced challenges relative to urban areas in meeting nationally imposed minimum threshold standards associated with health-related and non-health-related aspects of service delivery.
  - There are examples of *good practice* and there has been *innovation in rural areas,* yet there has been no detailed mapping of programmes and funding streams, or an analysis of the extent they have supported innovation in rural areas - including workforce development".

4.5 GUIDING PRINCIPLE 5: Better Practical Support for Families and Carers

- All respondents recognised the very important role this had to play. A number of respondents cited examples of facilitated and managed networks for families and carers. In a number of cases IT approaches were being used to seek to overcome the challenges of sparsity. The development of flourishing communities in rural settings through indirect investment (i.e. in activities which weren't directly care related) was cited as an activity likely to underpin a better environment for families and carers to operate in.

- The provision of respite care in rural settings was referenced as a key challenge for families and carers in rural settings. The importance of providing good quality information services to promote resilience amongst rural carers was identified as an area of good practice.

- Profiling potential developments amongst those with the greatest likelihood of need to support preventive strategies and tailor the support available to individuals were cited as examples of good practice. This was referenced by one respondent as being about "pre-eligibility" awareness.

4.6 GUIDING PRINCIPLE 6: A Sustainable Funding Model for Social Care Supported by a Diverse, Vibrant and Stable Market

- All respondents identified this as an aspiration rather than a reality. The use of preventive funding strategies to reduce the scale and growth of the level of adult care need was referenced as a general point applying in both urban and rural settings.

- A lack of providers, a lack of suitable housing, exacerbated by a complex operational framework, with significant distances between agencies and poor IT connectivity were all cited as severe challenges in rural settings.

- Identifying local and “place” specific contracting approaches to the challenge of providing services in rural settings were identified as key factors in seeking to address the problems arising from rurality.

- 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”.

- Once the issue of funding is resolved the Care Home and Care Provider Sectors in rural areas will become regarded, as they should be, as a significant and essential part of the rural economy in general.

4.7 GUIDING PRINCIPLE 7: Greater Security for All

- Managing expectations about what is practical in terms of budgets, particularly in view of the additional costs of providing services in rural settings was cited as a key element of addressing this principle.

- The burgeoning costs of supporting people with disabilities was identified as a challenge which was as severe and as exacerbated by rurality as adult social care. The patchy operation of the direct payment system was identified as an area requiring further attention.

- The development of a two-tier system in terms of the quality and range of residential care choices was identified as being more starkly split between local authority and self - funded clients in some rural areas. This was put down to the limited range of residential care options in some rural settings.

- The development of micro-providers of care (based on examples of the work of organisations such as “Community Catalysts” in Somerset who presented evidence directly to the APPG) was referenced as a key innovation making care more local and

more affordable in some rural areas, and also creating opportunities for entrepreneurship and employment.

- The challenge of predicting and therefore planning for the likely demands of older residents was identified as a general point, which is exacerbated by sparsity. The factors which made this more of a challenge in rural areas were cited as: limited choice of providers, greater distances between clients, poor IT provision in some rural areas and in many cases a lack of co-terminosity in terms of geography amongst the agencies concerned. Overall there was a strong degree of pessimism about being able to deliver this aspiration under current funding conditions.

CONCLUSIONS IN RESPECT OF THE SEVEN PRINCIPLES
1. The rural authorities that responded have a high proportion of their population as over 65 residents.
2. Dispersed population patterns lead to higher service provision costs in terms travel to care distances and reduce the contact time that can be allocated to clients. This can be exacerbated by seasonal weather fluctuations.
3. In many rural areas there are very few providers of social care to choose from due to the relatively high cost of providing services and the small number of clients.
4. Clients with complex support needs in rural areas are harder to support because of the distance between the agencies involved in providing care. Some residents require two care workers to provide their care in their own home. The workforce challenge increases the difficulty in accessing care for these rural residents, as to access two people to provide care and arrive at the same time increases the practical challenge of delivering services.
5. The ability of voluntary and community sector organisations and private sector providers to recruit nurses is a challenge and for the reasons stated in this report this is also heightened in rural areas.
6. The overall demography of rural areas means there is a smaller stock of workers to support those needing adult social care.

7. **Low wages and high housing costs make it difficult to recruit and retain care workers in rural areas. As an example, house prices can be significantly higher in some rural communities, meaning that care workers are less likely to be able to live within these communities. This can subsequently increase their travel to work in rural areas and create difficulties recruiting and retaining staff in these areas.**

8. **The high level of replacement demand, linked to a higher proportion of care workers retiring compared to new ones entering the profession is a significant challenge in rural areas.**

9. **All the authorities responding have a high proportion of their net budgets allocated to supporting a very small proportion of their overall population. This is an issue, which is common to both rural and urban authorities.**

10. **Poor broadband and mobile connectivity limit the scope to deploy technological innovations to support people in their own homes for longer. They also limit the potential to deliver cost efficiencies in the management of health conditions by both older people and their support workers accessing/providing services remotely.**

11. **Notwithstanding the practical challenges facing rural areas in terms of connectivity there is a strong consensus that technological solutions provide real, but largely unfilled potential to improve outcomes for adult social care clients. The presentation to the APPG by Hampshire County Council on its use of Assisted Technology in its Social Care Services shows what can be achieved including examples where Broadband "efficiency" is not a totally limiting factor**

12. **Carers in remote settings find it more difficult and expensive to network and support each other in rural settings.**

13. **Direct payments have the potential to help stimulate very local enterprises providing care, but are not effectively rolled out, the people eligible for them are often not well supported in their use. In cases where vouchers are used, rather than direct financial payments, innovation and choice is further limited due to the limitations placed on the use of the vouchers.**

14. **The housing stock in rural areas often fails to match the needs of the vulnerable older population. There is an acknowledgement of the need for, but a lack of, adequate provision of extra care housing in many rural settings.**

15. The declining number of rural GPs has a knock-on effect in terms of support for vulnerable older people in rural settings and where they have a key role in preventive strategies limits their potential impact.
16. Whilst preventive strategies based on mutli-agency working and early intervention offer the potential to reduce rising costs they are more difficult to deliver in rural areas. This is because of the wide distribution of clients and the greater distances, which agencies seeking to work collectively have to overcome in pursuit of integrated care approaches.
17. The challenge of supporting people is getting worse. Very few providers appear to have a long-term plan for overcoming the scale of challenge they face under the current system of providing adult social care. There is a wide acknowledgement that not only does the funding regime for providing adult social care need to change but so do attitudes about what is expected.
18. Respite care is more difficult to provide in rural settings due to sparsity in terms of the number of eligible clients within manageable geographical bounds.
19. There is a very acute cost linked to providing support for younger and disabled local authority clients, which is equally as severe as the pressures put on local authority finances by adult social care. Taken together with adult social care and these costs are rapidly eroding the financial viability of many local authorities.

5.0 THE RURAL CONTEXT EXPLORED

5.1 HEALTH AND WELL-BEING IN RURAL AREAS

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"

5.2 THE DEMOGRAHICS AND HIGHER DEMAND IN RURAL AREAS

The Demographics

- 23% of England's rural population (of 9.3 million – 19% of the overall population and more people than live in Greater London) 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 show that by 2039 1 in 3 rural residents will be aged 65+ and of those 11% (currently 6%) will be aged 80+
- 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.

Examples of Higher Demand for Services in Rural Areas

- Recently published "Local Area Performance Metrics" showed that delayed discharges from hospital per 100,000 of the 18+ population were 15.4 in Predominantly Rural Areas compared to 10.9 in Predominantly Urban areas. Those are very telling statistics

- The following statistics are taken from HHS Digital, Summary figures regarding Adult Social Care Activity and Finance (2016-17 – the latest data currently available)

  - 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)

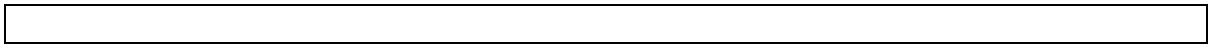
  - Support provided to carers during the year
    Predominantly Rural = 753 cases per 100,000 resident population
    15.9% greater than Predominantly Urban (650 cases per 100,000)

  - Number of 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)



APPENDIX A

EVIDENCE OF INEQUITIES IN THE CURRENT SYSTEM AFFECTING RURAL SERVICE PROVIDERS AND RURAL COUNCIL TAX PAYERS

(a) Generally, and Adult Social Care Specific

- As a consequence of the fact that rural areas have, over decades, 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 Local Government Finance Settlement for 2019/20 and those announced in recent months, will do relatively little to address the overall underlying funding crisis that these services face across England. Furthermore, the fact that much of this increase has to come from Council Tax is very 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 (IBCF), whilst insufficient to meet the Adult Social Care needs is, in principle, a step in the right direction. However, the Government's policy has built inequity into the system. The inclusion of Council Tax flexibility in the IBCF calculations means that, in practice, 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.

- Taking these things together, it is not surprising that, more government grant per head goes to urban areas. 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+ (and 85+), 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 indefensible.

- The 2018/19 Settlement re-enforces the view that it is acceptable to the Government that in rural areas Spending Power will be increasingly funded by council - taxpayers. In other words, the Government is prepared to see people in rural areas pay more Council Tax from lower incomes and yet receive fewer services than their urban counterparts**.**

- 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 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.

(b) <u>Prevention Services</u>

- Looking at the Public Health Grant Allocations shows –

For the year 2018/19,

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

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 tipping point action is needed to recognise and adequately resource prevention services to reduce demand on primary care.

- 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 Chief Executive of Public Health England in recent comments have recognised 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.