Manifesto for Labour in Wales

Part 3

Health and Local Government

Mike Hedges MS

September 2023

Table of Contents

Introduction 2
Structure of Welsh public services 2
Health Structure 5
Health needs 7
Primary care 8
Health inequality 9
Mental Health 12
Women's health 13
Dentistry 14
Health conclusions 16
Local Government structure 17
Local Government Services 19
Aligning services with the 4 Regions 21
Council size council tax and performance 22
Local Government Conclusions 31

Introduction

No pamphlet of this size can cover the structure of Welsh public services, Health and Local Government in detail.

The aim of the pamphlet is to both promote ideas and generate discussion.

Structure of Welsh public services

This looks at the structure of Welsh government funded public services in Wales

Health

This looks at health in Wales and gives some suggestions for improvement

It first looks at the current structure and produces some proposed changes.

It then looks at primary care and promotes the use of pharmacies

Then it considers the effect of health inequality and the effect on both life expectancy and quality of life

It examines mental health provision and the importance of mental health support

It looks at Women's health and how it needs to be of equal priority

NHS Dentistry is discussed

A number of conclusions are reached

Local Government

This looks at the structure of local government in Wales and the important services provided

Council tax council size and council performance

Regional footprint and joint working

Improving democracy

Council tax

Structure of Welsh public services

The organisation of the Welsh Government funded Welsh public sector.

Over the last 30 years there have been service reorganisations that have created larger organisations throughout the Welsh Government controlled public sector. There is generally a political consensus at the National Assembly that larger organisations are betters than smaller ones and that mergers are a good thing.

Currently in Wales we have:

• The Welsh Ambulance Service (WAST) that was established in 1998 by the amalgamation of four existing ambulance Trusts, and the ambulance service provided by Pembrokeshire and Derwen NHS Trust.

• Public Health Wales was created at the same time as the local health boards by the merger of National Public Health Service, Wales Centre for Health, Welsh Cancer Intelligence & Surveillance Unit, Congenital Anomaly Register & Information Service for Wales, and Screening Services Wales

. • 7 local Health boards that now plan, secure and deliver healthcare services in their areas, replacing the 22 LHBs and the 7 NHS Trusts which together performed these functions previously.

The population sizes vary between Powys at just over 130,000 to Betsi Cadwaladr at just under 700,000.

• The National Procurement Service was more recently created by the Welsh Government on 12 March 2013. Its remit is to secure in the region of £1bn worth of goods and services in common and repetitive spend.

• Natural Resources Wales was formed by the merger of the Countryside Council for Wales, Environment Agency Wales, and the Forestry Commission Wales. Since its creation there has been a number of loans from Invest to Save to fund redundancies and highly critical auditor general reports regarding the sale of trees.

• 2 Trunk Road agencies have replaced the former 8 County Council run agencies. The Welsh Government reviewed the way in which trunk roads and motorways were being managed, and they decided to reduce the number of trunk road agencies from eight down to three and then down to two.

• 3 National Parks. Following the Environment Act 1995, each national park has been managed by its own national park authority since April 1997. Previously they were governed by the local county councils. There have been calls for the three to merge into one National Park for Wales but that has recently been rejected.

• 3 Fire and Rescue services which were formed as a consequence of local government reorganisation in 1995, replacing the 8 former County Council Fire and rescue services.

• 4 regional Education Consortium created from the 22 unitary authorities in Wales responsible for education.

• 22 County or County Borough councils were created in 1995 by the merger of county and district councils. For several years there have been calls from politicians for local government mergers

. • Over 700 Community and Town Councils

Are mergers always right? From the above it can be see that the direction of travel is to larger and fewer organisations. Those who look at it simply, calculate the savings from reducing the number of senior staff and thus provide more money for front line services.

Mergers are expensive with redundancy costs and the cost of re badging the organisation. More expensive is creating a single ICT system from the systems of the predecessor organisations. Some will still be under contract and others will need to be updated or closed down and merged into the new system.

All these are up-front costs, and whilst the cost of local government reorganisation in 1996 was approximately 5% of annual expenditure for each council, that was without the variations in terms and conditions between authorities that exist today.

The simplistic conclusions of some is that following a merger, all the senior post duplication is removed and thus substantial ongoing savings are made. This ignores two major issues, namely that senior managers carry out tasks and if the number is reduced the tasks have to be reassigned and the same number of decisions need to be made.

Economic theory predicts that an organization may become less efficient if it becomes too large. Larger organisations often suffer poor communication because they find it difficult to maintain an effective flow of information between departments, divisions or between head office and outlying parts.

Coordination problems also affect large organisations with many departments and divisions as they find it much harder to coordinate operations. ‘X’ inefficiency is the loss of management efficiency that occurs when organisations become large and operate in uncompetitive markets. Such loses of efficiency include over paying for resources, such as paying managers salaries higher than needed to secure their services, and excessive waste of resources.

This leads to three questions on public services as they are currently configured.

Do the larger organisations such as Betsi Cadwalladr perform better than smaller ones?

Has the creation of all Wales organisations such as the Welsh ambulance service produced an improved service?

Has the reduction in the number of organisations carrying out a function such as the trunk road agency, Natural Resources Wales and the National Procurement Service improved the services being provided

Health Structure

We currently have:

One Welsh ambulance service following amalgamations in 1998. Having the ambulance service run separately to the hospitals does not work. Ambulances stacked outside hospitals and unable to attend 999 calls is the responsibility of the Welsh ambulance service not of the health board.

Public health Wales. The aim of national public health agency in Wales is to protect and improve health and well-being and reduce health inequalities for the people of Wales. More needs to be done on improving public health thus reducing health need and having a fitter healthier population.

Digital health care Wales. The aim is to provide world leading digital services, empowering people to live healthier lives. Supporting frontline staff with modern systems and secure access to information about their patients, available wherever they want to work.

The question is, is it effective, could what it does be dealt with more effectively and efficiently at health board level.

Seven health boards varying in population size from Powys at about 130,000 to Betsi Cadwalladr at just under 700,000 covering primary and secondary care. Since the health boards were set up primary health clusters have been created by the general medical practices, dental practices, pharmacies, nursing homes, and opticians in a pre-defined area.

This raises two questions , firstly does the health board structure work and is a better structure possible.

It is stating the obvious that Betsi Cadwalladr health board has had a series of problems over many years. Whilst in terms of population it is not exceptionally large but the geographical spread and transport difficulties create problems.

The Swansea bay university health board has three general hospitals based at Morriston, Singleton and Neath Port Talbot.

Morriston is a centre of excellence for urgent and emergency care, specialist care and regional services including complex medical interventions.

Singleton is a centre for excellence for planned care, cancer and diagnostics .Whilst planned care is by nature non urgent; it is essential for patients awaiting medical intervention.

Neath Port Talbot hospital is a centre of excellence for orthopaedics, spinal care, rehabilitation and rheumatology plus it has a minor injuries unit.

Where a health board can act a single hospital on different sites it works well.

If it cannot and if there is a duplication of services on different sited what is the advantage of a health board.

If the same services are provided on more than one site why should they not be treated separately. Why add another layer of management without the benefit of centralising services as SBUHB is doing.

Health needs

We all want the two things from the NHS one is the best possible medical intervention, and the other is a service as local as possible. I believe that the over-riding importance in hospital provision is that the service is safe and staffed by suitably qualified and experienced doctors and medical staff.

With some conditions and diseases there are centres of excellence both in Britain and within Wales including the burns and plastic unit at Morriston hospital. Within Hywel Dda and SBUHB a hub and spoke model for renal services centred on Morriston hospital works well.

A easy to access public list for patients of what services are to be provided locally and those that are regional would be helpful.

All patients who need to be in a hospital should have access to comprehensive medical treatment along with diagnostic and rehabilitation facilities which will allow for quicker recovery and discharge. Alongside this we need to strengthen community services helping people live as independently as possible in their communities.

Orthopaedics waiting lists and waiting times are too long, that is why I support a national orthopaedic recovery and transformation strategy to safely bring down waiting lists in Wales. I commend SBUHB for creating at Neath Port Talbot hospital a centre of excellence for orthopaedics, spinal care, rehabilitation and rheumatology.

When patients have to travel for treatment there is a need for adequate public transport for relatives to be able to visit.

People waiting for orthopaedic services need to receive communications, sign posting and support to help them with the physical and mental health challenges.

How many patients leave home for a knee replacement and then end up being discharged into a care home. An explanation of the risk and benefit needs to be given to patients prior to the operation.

The health service needs more doctors, nurses and allied health professionals. We currently recruit from abroad but we should be aiming to increase training places so that future health needs are met.

I want to highlight the importance of outreach facilities and treatment of patients in their own homes focussed on providing more joined-up services, in community settings – removing many of the current frustrations expressed by those both using and working within the system; also this often leads to better outcomes.

Primary care

For most patients primary care is the first point of contact. GPs now work alongside other health professionals in local surgeries and purpose built health centres. Patients do not always need to see the GP and the surgery can recommend seeing another health professional to deal with their health issue.

The aim has to be to help patients stay at home and in their community for as long as possible because we know this is better for both physical and mental health well-being.

Hospitals should be reserved as somewhere patients attend only as necessary, so what goes wrong. We have long queues in A+E, ambulances waiting outside hospitals, no hospital beds available and large numbers of patients contacting their GPs.

Patients are unable to get a GP appointment because they cannot get past the receptionist and all appointments are gone. The only place you can guarantee to see a doctor is at A+E although the wait can be very long.

Some suggestions

- Patients use pharmacies as a first contact for common ailments. It would help if pharmacists displayed their qualifications. Many people think the pharmacist is the person selling them over the counter medicines and hair products.
- There is a need for out of hours GPs at A+E departments to deal with non-medical emergencies.
- Train GP receptionists to the standard of basic para medics so they can confidently refer to other health practitioners.

Health inequality

It is well known that those who are least well off are more likely to suffer debilitating illnesses and die young. We know the gap in life expectancy between the poorest and wealthiest areas is increasing.

We need to address the social contributions to poor health including loneliness and Isolation, poverty, poor quality accommodation and poor nutrition. A public health Wales report acknowledged that social connections and engaging in community life is an essential part of wellbeing. Too many of our older citizens rely on the TV or a pet to provide them with company.

It has been identified that levels of deprivation varied considerably with pockets of deprivation in urban centres and the upper south Wales valleys. Areas of deprivation have higher smoking rates, higher obesity rates, lower activity and fitness rates leading to poorer health and shorter life expectancy. Obesity is an increasing problem with some children of primary school age being obese. We know obese children are likely to grow into obese adults.

Quitting smoking is a great way to improve your health but there are also so many other benefits that aren't always first to mind. Within one week your sense of taste and smell may have improved. Within three months you will be coughing and wheezing less, your immune function and circulation to your hands and feet will be improving, and your lungs will be getting better at removing mucus, tar and dust.

We need to work on stopping smoking, improving diet, increasing exercise and reducing obesity to reduce ill health and increase life expectancy. Improving the health of a community will not only reduce health service costs but will also improve life chances of those who otherwise would face a life of continual ill health followed by an early death.

Before it was unfortunately closed down community first had slimming, cooking, lifestyle and fitness programmes to help improve health. I remember the obese, heavy smoker and drinker, with a poor diet who considered himself unlucky with his health.

We have known for several years that there is a large discrepancy in life expectancy and healthy life expectancy depending on individual wealth based upon the area that people live. A 2020 report by ONS showed the gap in life expectancy at birth between the least and most deprived areas in Wales was 9 years for males and 7.4 years for female. Females living in the most deprived areas of Wales can expect to live 19.1 years less in "good" health

compared with those in the least deprived and the gap is 18.2 years for males. Is it any surprise that those who live in dry, warm homes, eat a balanced diet and do not spend their days worrying about heating their homes and feeding their families live longer and healthier lives.

What the cost of living crisis is causing is more people, many in stable employment or with occupational pensions, suffering the health effects of inadequate diet, cold homes, and constant worry over the lack of money.

We know older people are particularly vulnerable to cold , for an older person with a body temperature below 35 degrees centigrade there is a risk of health problems such as hypothermia, heart attack, liver damage and kidney problems. Research from around the world continues to show that those children in cold and damp houses are at increased risk of poor health, the number of which are increasing due to the cost of living crisis.

We all know the importance of a balanced diet, but fresh and less processed foods are the more expensive food choice. Now recent food cost rises are pushing these healthier options further out of the reach of large numbers of people. Instead, families are turning to cheaper, less nutritious food options such as microwave meals, or cutting back on food completely. I have met mothers who go days without eating in order to feed their children, who eat toilet paper in order to fill their stomachs and this is happening in 21st century Wales.

A diet with lower nutritional quality increases the risk of health issues, such as Type 2 diabetes, heart disease and stroke. On Diabetes, Diabetes UK says data suggests poor diets linked to the cost-of-living crisis is causing concerns and the impact is being disproportionately seen in deprived parts of Wales.

With the difficulty in being able to travel then there is an increased risk of isolation which is where the free travel for the over sixties in Wales is helpful. Also, there is the stress experienced each time vehicles are filled, or partially filled with fuel which is also likely to affect mental health.

The health risks include the difficulty in accessing healthcare which can result in late or missed diagnosis and treatment. Increased isolation and loneliness can lead to depression, and anxiety.

Financial stress can reduce the quality of life. People who were in the just about managing category are now in financial difficulty, many, for the first time. Financial worry should not

be underestimated, imagine the first thing that you think of each morning is lack of money for essentials and that worry stays with you all day. How soon can I access the foodbank, will putting more clothes on reduce heating costs, can the food be eaten cold.

Stress can have a massive impact on our day-to-day lives and reduce our quality of life. There is evidence that long-term stress can develop or worsen several mental and physical health conditions.

As the cost of living crisis makes more people have financial problems then the health of many will deteriorate and for some unfortunately it could prove fatal.

Mental Health

Mental health is no less important than physical health and mental health problems can affect people of all ages.

I welcome the online resource dedicated to helping young people aged between 11 and 25 to access mental health support. Young people are growing up in a world of social media, where some are made to feel inadequate and where bullying can occur 24hours a day.

The refreshed young person's mental health tool kit is available via the educational website Hwb, the National Digital Learning Platform. The toolkit features links to a range of external websites, apps and helplines that are designed to support young people with their mental health and wellbeing. The toolkit provides a single point of access to well-known organisations that support young people.

Just as our physical health may vary throughout our lives, sometimes our mental health will be positive, at other times we will experience poorer mental health, and some of us may become more seriously mentally unwell.

Our mental health is linked with our physical, emotional, and spiritual health, and the circumstances in which we live. Connecting poor mental health with its wider causes, particularly in the context of the rising costs of living, gives us the opportunity to address those causes, not just patch up the symptoms.

Connecting people with their communities, and bringing communities together, can create environments and circumstances which support, promote and nurture positive mental health and wellbeing. Connecting services will help the mental health and wider workforce to work together, and to co-produce solutions and resources with people with lived experience to ensure that everyone can get the help and support they need, where, when and how they need it.

Mental health treatment can take place at a dedicated community mental health centre, a day clinic that operates out of the local hospital, or in some larger GP surgeries. People can agree to an admission to hospital if their psychiatrist recommends that this is the best could of care and treatment.

Women’s health

Women, and girls, make up around 52% of the population in Wales. Despite this, historically, medicine and healthcare services have not necessarily met their needs, resulting in significant disparities in care.

Undoubtedly, the pandemic has exacerbated the problem: the Royal College of Obstetricians and Gynaecologists last year published a sobering report, ‘Left for Too Long’ which asked why it is that ‘the waiting lists of the only speciality that caters just for women have grown the most of all specialties since the start of the pandemic? Why is there so little discussion or recognition of the impact on women’s lives of waiting for gynaecological care and treatment? And how much has the perception of many of these conditions as ‘benign’…played in to the lack of priority they have long been given.

It’s important to note that women’s health isn’t solely comprised of gynaecological matters but the issues surrounding care for related conditions is a reliable indication of wider problems

Autoimmune conditions like lupus and inflammatory arthritis, connective tissue disorders like Ehlers Danlos Syndrome, conditions causing pain and fatigue like fibromyalgia or ME and Long Covid , all of these affect women in far greater numbers than they do men, and all of them seem to suffer from the same lack of investment in research, treatment, and specialist care.

For Endometriosis are on waiting lists of two to three years, or even longer if affected by the most severe form, which requires highly specialised and multi-disciplinary care. This type of offer is only available in certain areas of Wales, and if you’re unfortunate enough not to live nearby, you may well be denied treatment altogether.

The British Heart Foundation estimates that at least 100,000 women are living with heart diseases in Wales. The most common of these is coronary heart disease with around 45,000 women in Wales living with this condition. Wales has the second highest coronary heart disease female death rate of the UK’s four nations with around 1,300 women dying every year — that is twice as many deaths as breast cancer. It is now for the NHS to take action to tackle the unconscious biases and disadvantages women experience at every stage of their heart disease journey.

I welcome the FTWW’s solution which is to work with the British Heart Foundation Cymru in forming a Women’s Health Wales Coalition.

Dentistry

There are problems with getting an NHS dentist and dental practices are reducing and, in some cases, terminating their NHS contracts, including for children.

I along with many other people would like NHS Dentistry to be available to everyone who wants it. Along with other Members of the Senedd, I met with Morgannwg Local Dental Committee which represents dentists and dental practices in the Swansea Bay University Health Board area.

Following that meeting I have requested, that the Minister directly engages with the representative body of NHS dentists (British Dental Association Wales).

Those dentists carrying out NHS work are committed to the principles of the national health service. The issues they raised included the new contract and that dentist signed up to the contract without the detail which emerged later. This was meant to be a lenient learning year, but that does not appear to have happened.

There is a need for a new dental school in Wales, and I have suggested Swansea University as a possible site, though I am sure people in the north will suggest Bangor.

I think it is important that we have another dental teaching centre at a site where we already have a medical school. If we do not have enough dentists, I support training more to fill the vacancies.

Issues have emerged which are affecting dental care and may mean that many dentists exit their contract. Around 75 per cent of dentists surveyed by the British Dental Association said that the contract was not working for them. The co-production meetings on the contract have increasingly lacked co-production.

In 1948, NHS Dentistry was introduced as part of the newly formed National Health Service. There were three fundamental principles: no-one should ever have to worry about being unable to afford necessary medical care; care would be provided free at the point of delivery, and care would be based upon clinical need.

The Dental Contract has gone through many changes. The original payment system was fee per item, where dentists were paid for each treatment they provided and this was used between 1951, when Patient Charges were introduced, and 1990, and the system worked well for both patients, dentists and the government.

The system was changed in 1990, involving dentists being paid a fee for each treatment, as well as an allowance for registration of adult and child patients.

The Units of Dental Activity (UDA) were introduced in 2006. The contract involved dentists being paid for a set number of UDAs per year, with each band of treatment assigned a certain number of units.

This was not trialled and was flawed from the start. This meant that a treatment containing 1 filling was paid the same as a treatment that required, a recipe for financial disaster.

Furthermore, the value of a UDA was different for different practices, sometimes by more than £10.

The system worked against both dentists and patients – patients with high needs (lots of fillings needed) were finding it difficult to get treatments done. It has been recognised from the outset of this contract that it was not fit for purpose which resulted in the trialling of alternative contracts.

The prototype A B system was introduced in 2011 as a trial for a new contract system. There were two prototypes in Wales. One was the quality and outcome pilot, and the second, a children and young people's pilot.

Both removed the unit of dental activity and gave freedom to make clinical judgment on what is best for the patient.

The latest contract system started in 2019 and is called 'Contract Reform.' Every time I hear the term 'reform' or 'modernisation', I break out into a cold sweat.

Under the system, dentists are paid for a set number of units of dental activity per year (25% of their Contract Value) with other Key Performance Indicators making up the other 75%, with the emphasis on preventative care and patient outcome, which is good, but clawback has generated huge concern for dental practices.

There is also confusion in the local dental workforce as to how the metrics work, how they have been derived and the evidence of their validity – some metrics are impossible to meet for some practices e.g. there is a target number of historic patients to be seen in a contract year based on a percentage of contract value, some practices' numbers of historic patients are lower than the target, which is therefore impossible to achieve.

The dentists suggested some solutions: dental contractors are paid the same rate for each item of treatment they deliver; a weighted capitation scheme needs to be considered and dentists should be rewarded for seeing higher risk patients more regularly and for providing more complex treatments which take up more time.

Everyone, patients dentists, and politicians, wants NHS dentistry to work for patients.

Health conclusions

There is no magic wand but changes are necessary to stop the health service becoming overwhelmed.

- The ambulance service should be split up and run by individual health boards
- If a health board cannot organise different services on different sites then it is reduced to a size of one that can even if it is down to one hospital
- A list of what are local hospital services and regional hospital services is produced
- A national orthopaedic recovery and transformation strategy is produced
- Sites are identified as centres of excellence for orthopaedic and related treatments
- GP receptionists trained to the level of basic para medics
- Promote the use of pharmacies for minor ailments
- Out of hours GP service at every A+E department
- Programme needed to end smoking, improve diet, increase exercise and eradicate obesity
- Targeted action on obesity in children
- Improve support for mental health
- Treat women's health as of equal importance to men's
- Gynaecological conditions should be treated at the same rate as other conditions
- Dental contractors are paid the same rate for each item of treatment they deliver
- A weighted capitation Dentistry scheme needs to be considered, remember, we used to have that,
- Dentists should be rewarded for seeing higher risk patients more regularly and for providing more complex treatments which take up more time.

Local Government structure

I have previously looked at the changes in structure of the public sector in Wales and how the performance of local authorities varies with size. Now I am addressing how I believe we can take the public sector in Wales forward. I believe that all change should be based on the answers to these questions:

• Is the current structure providing effective services?

• Is the structure responsible, in part or whole, for the weakness of the organisation or its failure?

• Is it close enough to the people so that they feel ownership of it?

• Will the new structure improve service delivery. We need the same regional footprint for all public services provided by the Welsh Government.

To give an example of current inconsistency: those of us who live in Swansea have a different regional footprint for almost every service. For health, Swansea, and Neath Port are combined; the Fire and Rescue Authority covers Swansea, Neath Port Talbot, Carmarthenshire, Ceredigion, Powys and Pembrokeshire; the educational improvement boundary is the same but policing, which is currently non-devolved, includes all the former county of Glamorgan except for Caerphilly;

Finally, the Welsh Ambulance Service covers the whole of Wales. The aim should be to have all services within the four footprints of Wales: the Cardiff City region; the Swansea City region; mid Wales and north Wales regions. Whilst services could, and in many cases will, be on a smaller footprint than the regions, no service should cut across the regional boundaries unless it is an all-Wales service which would be very rare and include things such as forestry, where regionalisation would not be of benefit.

This will allow regional working across services to be undertaken far more easily. There is nothing intrinsically good about the current structure of local government in Wales. Why were the councils of Rhondda, Cynon Valley and Taff Ely merged into one but Blaenau Gwent and Merthyr district Councils turned into unitary authorities?

Change should only be considered where there is a very strong chance of improving services and/or reducing cost over the medium term because of the initial cost of change. Having spent several years discussing local government reorganisation as if it were some silver bullet to solve the lack of funding for councils, the threat of reorganisation initially receded was brought back and has now receded again. It was as if the economic theory that predicts that an organization may become less efficient if it becomes too large or diseconomies of scale were unknown.

Different services need different methods of joint working, but most work best at the current local authority level. Examples of services that would benefit from a joint working model based upon the regional footprint are transport, economic development and regional planning.

Specialised social service provision and educational improvement could be dealt with by two or more councils working together within the regional footprint.

Within Wales, it is the councils that will know best what works for them and consequently they should be allowed to decide locally what works best for an area.

The revenue cost of PFI schemes is having a detrimental effect on the money available for public service provision. We owe a debt of gratitude to Rhodri Morgan for not getting seduced by the PFI schemes that have unfortunately proven so expensive for public service provision in England.

Nevertheless, Wales's PFI bill costs the Welsh public services £100m a year that could otherwise be spent on supporting local services. When Finance Minister Mark Drakeford stated: "There have been only 23 schemes in Wales and very, very little new PFI in the devolution era, and of those 23, 21 of them are not the direct responsibility of the Welsh Government, belonging to local authorities and to the health service.

But we are absolutely open to keeping under continual review whether or not those arrangements could be improved and a better deal secured for the taxpayer, and when we have the next Labour government, then our ability to do that will be much enhanced." Local authorities could also be encouraged to consider the use of prudential borrowing to remove PFI revenue costs "

The evidence that larger authorities reliably achieve economies of scale is equivocal, both in the UK and elsewhere;

There is no automatic relationship between larger authorities (in terms of population size) and more effective services. Larger authorities do perform better in some service areas in some states, but studies have also found examples of poorer performance by very large authorities, and examples where no direct relationship can be identified;

There is some evidence that larger local authorities are less 'democratically responsive': that is, that they can be associated with reduced public satisfaction, reduced political participation, or lower electoral turnouts.

Local Government Services

Councils provide more than several hundred services to their communities. They are obliged by law to offer most of these services because provision is laid down in statute.

There are 1,300 different statutory duties and responsibilities, such as social care for the elderly, education, maintenance of green spaces, and road repair.

Key services provided include

- **Education** for example providing schools, transport to get children to school and providing opportunities for adult learning
- **Housing** such as finding accommodation for people in need and maintaining social housing
- **Social Services** for example caring for and protecting children, older people and disabled people
- **Highways and Transport** including maintaining roads and managing traffic flow
- **Waste Management** including collecting rubbish and recycling
- **Leisure and Cultural Services** for example providing libraries, leisure services and arts venues
- **Consumer Protection** such as enforcing trading standards and licencing taxis
- **Environmental Health and Services** for example making sure that the food provided in pubs and restaurants is safe to eat, and controlling pollution locally
- **Planning** including managing local development and making sure buildings are safe
- **Economic Development** for example attracting new businesses and encouraging tourism
- **Emergency Planning** for things like floods or terrorist attacks

Councils provide some services directly, work in partnership with other organisations to provide others and can commission organisations in the private and voluntary sectors to provide services on their behalf.

There is a widely held belief by Council tax payers that their Council Tax pays for the services provided by the Council. What has happened in recent years is that Council Tax has increased whilst services have reduced and Council Tax payers have had a variety of reactions varying between anger and confusion.

This is because Council Tax pays for less than a quarter of the total Council services cost with the rest being funded by the rate support grant and the Councils' share of business rates both provided by the Welsh Government.

The business rate payment to a Council is not related to the business rates collected in the area but is distributed via a formula. Some Council areas are net contributors to the national business rates, most notably Cardiff, whilst others are net gainers from the system.

With expenditure on Education and Social Services approximately 65% of the total expenditure Councils. This means that if Councils protect Social Services, which is a demand led expenditure and Education expenditure then any cuts made by local councils

disproportionately affect the other services. This is what we have seen occur throughout Wales irrespective of either type of area or political control.

Libraries, sports facilities and other discretionary or non-statutory services have seen substantial cuts. This disconnect between the Council Tax bill and the level of service provided is bad for democracy and bad for Local Government. As other areas of council expenditure are cut in order to protect Education and Social services the percentage spent on Education and Social Services can only increase.

.

Aligning services with the 4 Regions

As an enthusiastic supporter of City regions, I believe they can be a lot more than an economic development entity. It is very important that the region gets a city or regional deal and that we use it to regenerate our economy.

In the Swansea city region the aim of the city deal is to address the integrated universal themes and challenges of energy, health and well-being and economic acceleration by harnessing the transformational power of digital networks and the asset base of Swansea Bay.

It is estimated that the City Deal investment could lever in total around £3.3bn. The City Deal will see the Swansea Bay City region become a giant test bed that innovates, trials and globally commercialises smart internet based solutions that will transform the local, Wales and UK economy, energy and health sectors in much the same way as the internet has already transformed the telecommunications industry.

If we believe, as I do, that the Swansea Bay City region covering the Council areas of Neath Port Talbot, Swansea, Carmarthenshire and Pembrokeshire is a coherent sub Wales region then the obvious next step is for all public services to be run within this footprint.

What we do know is, by either visiting local employers, or just looking at the early morning and evening traffic is that a large number of people move around the region for employment. Whilst currently the Welsh Government has no control over the Police service and so cannot align policing with the area but all the or services under Welsh Government control can be aligned.

Obviously this cannot be done immediately but as the structure each service is reviewed then the structural changes necessary to align services within the city region must be taken.

Firstly and most simply is Fire and Rescue that can be easily realigned to the City region boundary as it would only mean the transfer out of Powys and Ceredigion.

Secondly if it is going to be an economic sub region then what is needed is to have a development plan equivalent to the old county development plans to cover the whole area. This would ensure that housing and economic development planning can be aligned over the whole region and not only on a local authority area.

The development of the bay campus which is in Neath Port Talbot but which has had a greater effect on Swansea than on Neath Port Talbot is an example of the need for an area based approach. The third whole Swansea bay city region policy co-ordination that is needed is a transport strategy, the Swansea bay equivalent of the Cardiff city region metro system.

This needs to ensure that there is coherent rail and bus network that can move people from the residential areas to the main employment sites. Also the road network needs to be such that movement between major population centres is via at least a dual carriageway. Within the city region a simple subdivision into two can be done (West Glamorgan and Dyfed) which equates to the former counties of Dyfed (minus Ceredigion) and West Glamorgan.

Council size council tax and performance

Does size produce better services and lower council tax because of the suggested efficiency of scale?

The current size of local authorities in Wales are shown below.

RANK	DISTRICT	POPULATION
1	Cardiff	361,500
2	Swansea	244,500
3	Rhondda Cynon Taf	238,300
4	Carmarthenshire	185,600
5	Caerphilly	180,500
6	Flintshire	154,400
7	Newport	149,100
8	Bridgend	143,200
9	Neath Port Talbot	141,600
10	Wrexham	136,700
11	Powys	132,200
12	Vale of Glamorgan	128,500
13	Pembrokeshire	124,000
14	Gwynedd	123,600
15	Conwy	116,500
16	Denbighshire	94,800
17	Monmouthshire	92,800
18	Torfaen	92,100

19	Ceredigion	74,100
20	Isle of Anglesey	69,700
21	Blaenau Gwent	69,600
22	Merthyr Tydfil	59,800

England and Scotland have several unitary authorities larger than Cardiff but Scotland has 5 smaller than Merthyr (Inverclyde, Clackmanshire, Western Isles, Orkney, and Shetland) and England one (Rutland).

If larger authorities were more efficient and effective then two things would happen: council tax would be lower and performance would be better. The council tax should show that the larger authorities, and Powys which has been deemed not to need to be merged, charging the lowest amount. Using Welsh Government data on 2018/19 County and County Borough Council tax rates.

DISTRICT	BAND D COUNCIL TAX	RELATIVE SIZE
Pembrokeshire	994	13
Newport	1,057	7
Caerphilly	1,058	5
Wrexham	1,093	10
Isle of Anglesey	1,140	20
Cardiff	1,155	1
Conwy	1,168	15
Flintshire	1,178	6
Vale of Glamorgan	1,187	12
Powys	1,189	11
Carmarthenshire	1,197	4
Ceredigion	1,226	19
Torfaen	1,242	18
Monmouthshire	1,242	17
Denbighshire	1,248	16
Swansea	1,269	2
Gwynedd	1,301	14
Bridgend	1,396	8
Rhondda Cynon	1,406	3
Neath Port Talbot	1,497	9
Merthyr Tydfil	1,500	21
Blaenau Gwent	1,571	22

Whilst the two smallest authorities are in the bottom two places regarding council tax, medium-sized authorities appear to perform better than either large or small authorities when it comes to the cost of council tax to the resident.

Does council performance show that the larger authorities by population perform best? According to the Western Mail " the quality of services delivered by local authorities in Wales is not determined by the size of the council." The Western Mail figures are based on 28 indicators across the range of local government, including education, social care, housing, environment and transport, planning and regulatory services, leisure and culture and corporate health.

With four points on offer for councils that performed in the top quartile of each indicator, a maximum score of 112 was possible. Depending on their performance, councils scored between one and four points in each indicator. This uses figures published in 2015/16 and I will update these figures when I can access more recent figures.

COUNCIL	SCORE	SIZE
Vale of Glamorgan	86	12
Denbighshire	85	16
Carmarthenshire	79	4
Pembrokeshire	77	13
Rhondda Cynon Taf	77	3
Merthyr Tydfil	76	22
Wrexham	76	10
Neath Port Talbot	73	9
Gwynedd	72	14
Flintshire	71	6
Caerphilly	70	5
Conwy	68	29
Isle of Anglesey	68	29
Blaenau Gwent	67	21
Bridgend	67	8
Monmouthshire	66	17
Newport	66	7
Torfaen	66	18
Cardiff	64	1
Ceredigion	61	19
Powys	61	11
Swansea	59	2

From this, it is not possible to conclude that larger councils and Powys perform better with medium sized authorities taking three of the top four places.

In Scotland, the variation in council tax is much less than Wales but the lowest council tax is the Western Islands and Shetland and the largest Council, Glasgow, has the largest band D council tax.

I didn’t find it possible to get the same data for Scotland as is available for Wales on relative performance.

I look forward to reading an explanation, rather than an assertion, on how larger councils perform better and an explanation of the advantages of larger councils.

Council tax

Every property in Wales has been valued at its estimated 2003 value and placed into one of nine bands. All properties are banded on the same basis, including properties bought under discount schemes, such as the Right to Buy. The purchase price discounts applied to these properties aren't taken into account when setting the band. Whilst it seems that setting council tax band based upon 2003 valuations renders them out of date, England's are based upon 1991 valuations. Whilst property valuations can change following building work what is not taken into account is the relative popularity and price changes between different areas

Table 1 below shows the valuation for each band.

Table 1

Council Tax bands in Wales

Band	Value at 1 April 2003
A	up to £44,000
B	£44,001 to £65,000
C	£65,001 to £91,000
D	£91,001 to £123,000
E	£123,001 to £162,000
F	£162,001 to £223,000
G	£223,001 to £324,000
H	£324,001 to £424,000
I	more than £424,000

The number of properties in each council tax band varies between local authorities. Some such as Blaenau Gwent have over half their properties in band A and very few properties in the highest two bands. Monmouthshire by comparison has only just over one percent of its properties in band A and has almost 6 percent in the top two bands.

The number of properties in each band for each authority is shown in table 2.

Table 2

Council	Band A	Band B	Band C	Band D	Band E	Band F	Band G	Band H	Band I
Isle of Anglesey	4,860	6,840	6,730	7,260	5,430	2,610	1,040	160	50
Gwynedd	9,200	15,690	12,450	10,620	8,240	3,980	1,260	200	90
Conwy	5,350	8,220	15,360	11,780	9,010	5,010	1,890	430	170
Denbighshire	3,980	7,200	14,380	7,740	5,380	3,660	1,990	310	170
Flintshire	4,260	9,320	20,260	12,820	10,620	7,350	3,150	580	230
Wrexham	4,330	12,560	16,890	10,080	7,980	4,960	2,500	720	290
Powys	5,810	9,200	12,850	10,240	12,190	9,390	4,080	580	210
Ceredigion	1,940	4,920	7,490	7,410	8,930	3,720	930	110	20
Pembrokeshire	6,520	9,410	13,870	11,110	12,210	5,810	2,050	320	90
Carmarthenshire	9,190	24,220	18,160	14,120	12,940	6,340	2,120	300	70
Swansea	17,030	28,210	24,290	16,780	12,860	7,970	3,800	1,160	530
Neath Port Talbot	13,510	27,320	11,530	7,240	4,440	1,500	510	100	20
Bridgend	10,400	15,150	14,380	10,320	7,600	4,310	1,450	280	110
Vale of Glamorgan	1,360	6,200	13,540	11,110	10,060	7,050	5,510	2,190	1,020
Cardiff	4,040	19,130	32,470	35,260	29,620	20,980	9,950	2,730	1,430
Rhondda Cynon Taf	46,610	25,200	17,090	9,140	6,620	3,350	1,150	180	70
Merthyr Tydfil	14,130	6,660	2,190	2,160	1,470	560	150		10
Caerphilly	15,130	26,690	18,420	9,240	6,410	2,250	780	90	80
Blaenau Gwent	19,190	8,050	2,590	1,610	840	320	60		20
Torfaen	6,050	12,960	11,780	4,040	3,660	2,150	660	60	30
Monmouthshire	500	3,300	6,940	8,740	7,140	7,540	5,300	1,740	670
Newport	6,580	14,730	17,660	12,320	7,950	5,490	2,560	540	190

The Local Government Finance Settlement determines how much of the funding provided for Wales, will be given to each local authority. This funding contains the Revenue Support Grant (RSG) and non-domestic rates (NDR) and is distributed on the basis of a needs based formula. A joint Welsh Government and local authority working group, called the Distribution Sub Group is responsible for ensuring the formula is reviewed regularly. Other local authority funding is raised locally in the form of council tax which is set by each authority as part of its annual budget setting process as well as fees and charges collected by the local authority.

The distribution of properties in each band varies enormously and whilst some authorities have over half their properties in the lowest two bands others notably Monmouth have over half their properties in band D and above.

We would thus expect the Councils to get the largest Welsh Government support per capita to be Blaenau Gwent, Merthyr and Rhondda Cynon Taf and the three lowest per capita to be Vale of Glamorgan, Monmouth and Cardiff due to the scheme making up for the council tax able to be collected.

Table 3 shows the Welsh Local Government Revenue Settlement 2019–2020 and shows that the highest support per capita does go to Blaenau Gwent, Merthyr and Rhondda Cynon Taf and the least goes to Monmouth.

Table 3

Aggregate External Finance (AEF) plus top-up per capita, 2019-20

Unitary Authority	2019-20 Final Aggregate External Finance plus top-up funding (£'000s)	Final Aggregate External Finance per capita (£)*	Rank
Isle of Anglesey	95,791	1,365	11
Gwynedd	176,552	1,423	9
Conwy	154,192	1,317	15
Denbighshire	143,637	1,500	5
Flintshire	188,980	1,218	19
Wrexham	175,252	1,244	18
Powys	174,291	1,323	14
Ceredigion	102,091	1,333	13
Pembrokeshire	162,448	1,308	17
Carmarthenshire	260,388	1,397	10
Swansea	322,211	1,311	16
Neath Port Talbot	214,796	1,518	4
Bridgend	191,807	1,339	12
The Vale of Glamorgan	152,070	1,184	21
Rhondda Cynon Taf	367,339	1,537	3
Merthyr Tydfil	91,304	1,541	2
Caerphilly	268,614	1,482	6
Blaenau Gwent	110,815	1,597	1
Torfaen	132,650	1,440	7
Monmouthshire	93,229	1,002	22
Newport	214,343	1,436	8
Cardiff	444,629	1,201	20
Total unitary authorities	**4,237,431**	**1,352**	

We know that Council tax hits the poorest households particularly hard with low earners paying an average of 7% of their income in Council tax whilst the wealthiest households pay only 1.5%. (1)

Council tax is an outdated and regressive levy on households that should be scrapped in favour of a progressive levy on property, according to a report by the Resolution Foundation. Laura Gardiner, principal researcher at the foundation, said analysis showed that council tax has "only a very weak link to property values" that meant it was "highly regressive".

"Someone living in a property worth £100,000 pays around five times as much council tax relative to property value as someone living in a property worth £1m. This is exactly the kind of result that opponents of the poll tax wanted to avoid and in stark contrast to income tax, which increases with incomes in a progressive way so higher earners pay a higher average tax rate,"

Starting with the assumption that it is not intended to collect less council tax in the immediate future and that a change to another local tax is several years at least away, then what can be done to make council tax fairer.

The first and easiest is to add extra bands at the top of the banding system or bringing in a mansion tax.

I would suggest a band J at £1 million, a band K at £5 Million and a band L at £10 million. This would mean that those in very expensive properties would pay more. An alternative reform would be a "mansion tax" surcharge of 1% on the value of properties worth more than £2m and 2% on the value of properties above £3m, which would also generate just over £1bn in the UK.

I would further suggest ending single person council tax relief on properties above band G would mean that those in higher valued properties would not get a discount.

More difficult would be revaluations, as the National Non Domestic rate revaluation showed, where those who benefited from a reduction generally said nothing whilst those facing an increase complained loudly. This includes a petition on rates from Cowbridge retailers and Western Mail headlines such as “Stadiums in Wales to be hit by a huge hike in business rates” and “reform business rates now to save the Welsh High Street, retailers urge. I have been unable to find any examples of people celebrating a reduction in their business rate valuation.

(1) Independent 26th April 2017

Local Government Conclusions

There is some evidence that larger local authorities are less ‘democratically responsive’: that is, that they can be associated with reduced public satisfaction, reduced political participation, or lower electoral turnouts.

There is no automatic relationship between larger authorities (in terms of population size) and more effective services.

Councils provide more than several hundred services to their communities with over 1,300 different statutory duties and responsibilities.

It concludes Services should be aligned with the four regions unless they cover all of Wales.

Whilst some of the data is out of date the basic premise that Council size neither produces better performance or lower council tax still stands.

The government support for Councils per capita is proportional to council tax bands in the area

Council tax needs more bands especially at the top end so council tax is more proportionate to property value.