30 September 2021

Health Foundation submission to the Autumn Budget and Spending Review 2021

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

Summary of our submission

The COVID-19 pandemic has had a profound impact on population health, the NHS and social care. The government has provided £97bn of funding to help tackle the immediate pressures from the pandemic (over 2020/21 and 2021/22). But, as COVID-19 becomes an endemic disease, it is important that the Spending Review ensures continued funding to address the pandemic's legacy and build resilience, through investment in the health and care system and beyond to support better population health. COVID-19 has exposed a lack of resilience in the health of the population, and a lack of resilience and capacity in the NHS and social care. Both require investment and much better medium-term planning. As a result, COVID-19 affected vulnerable and older people far more than others: healthy life expectancy is significantly lower than life expectancy and inequalities are increasing. And unlike many health systems in western Europe with greater long-term investment and inbuilt spare capacity, the NHS is now left with an avoidably large backlog in care and significant staff shortages.

The new levy will provide funding for NHS England and to implement a cap on social care. Both are welcome but on their own will not quickly repair the damage from COVID-19, deliver the necessary improvements to health outcomes or build adequate population and service resilience. More investment, and more predictable investment over the medium term, will aid the planning now sorely needed.

In this submission, we highlight four key additional priorities for investment:

- the **public health grant** which supports interventions to tackle ill health upstream, where the evidence is that these interventions are highly cost-effective
- the **capital budget** and the **workforce** to ensure the NHS has the people and the facilities needed to meet the government's priorities and to increase capacity so that services can manage demand more effectively and efficiently
- **social care**, where the core means-tested system needs funding to ensure that more people can access high-quality care, that providers are more sustainable, and the sector offers pay, terms and conditions that enable staff recruitment and retention.

Together this would be a substantial financial commitment. But, as the pandemic has shown, the cost and societal impact of not building resilience across the population and the health and care system can be much greater. This investment would also contribute to the government's levelling up agenda: boosting public health, social care and NHS services would allow more people in ill health to work; filling care workforce shortages would boost skills and employment in areas and populations needing to be levelled up; and capital investment would help boost the productivity of the care workforce.

Key points

- To restore the public health grant to its historic real-term per capita value – accounting for both cost pressures and demand levels – would require an additional £1.4bn a year (in 2021/22 prices) by 2024/25. This represents an average growth rate in the public health grant of 14% a year for the next 3 years.
- We project that as a minimum, the NHS capital budget would need to grow in line with current plans and then continue to increase in line with the wider NHS budget. The Department of Health and Social Care's capital departmental expenditure limit (CDEL) would need to be more than £10bn in 2024/25, rising to around £12bn in 2030/31.
- With demand for services expected to increase, the health and social care workforce may need to grow by as many as a million staff by 2030/31. This includes a 40% increase in the health care workforce, more than double the growth for the NHS over the last decade.
- Action on every element of workforce supply is needed: training, attrition, recruitment (including overseas recruitment), and retention. The Health Education England (HEE) budget needs to keep pace with growth in the wider NHS budget. We estimate the HEE budget would need to rise to at least £5.5bn in 2024/25 and continue to increase to more than £6bn in 2030/31. This equates to growth of 3–4.1% a year in real terms between 2021/22 and 2024/25.
- Once funding for the cap on care costs is taken into account, we estimate that the government's recent announcement provides at most around £1.5bn a year to 2024/25 – compared with the £2.5bn needed just to meet demand and the £9.3bn needed to meet demand and to sustain and improve the current system.
- Up to 627,000 extra social care staff may be needed to improve services and meet need – a 55% growth over the next decade and four times greater than the increases of the last 10 years.
- It is vital that we do not take the same approach that followed the 2008 financial crash, where departments outside the health and care system faced funding cuts. A plan for longer term investment in quality public services must be set out, along with a cross-government health strategy to tackle risks to health and address health inequalities.

Please note that throughout, all growth rates are in real terms and absolute numbers are in 2021/22 prices (using the GDP deflator).

Creating healthy lives and investing in the public health grant

The pandemic has resulted in a range of risks to health, both immediate and longer term, from people being unable to access services through to education gaps and a loss of work or income. Within local authorities, the public health grant has a key role to play in improving health by funding vital services, such as smoking cessation, drug and alcohol services, children's health services and sexual health services, as well as supporting broader public health activities across local authorities and the NHS.

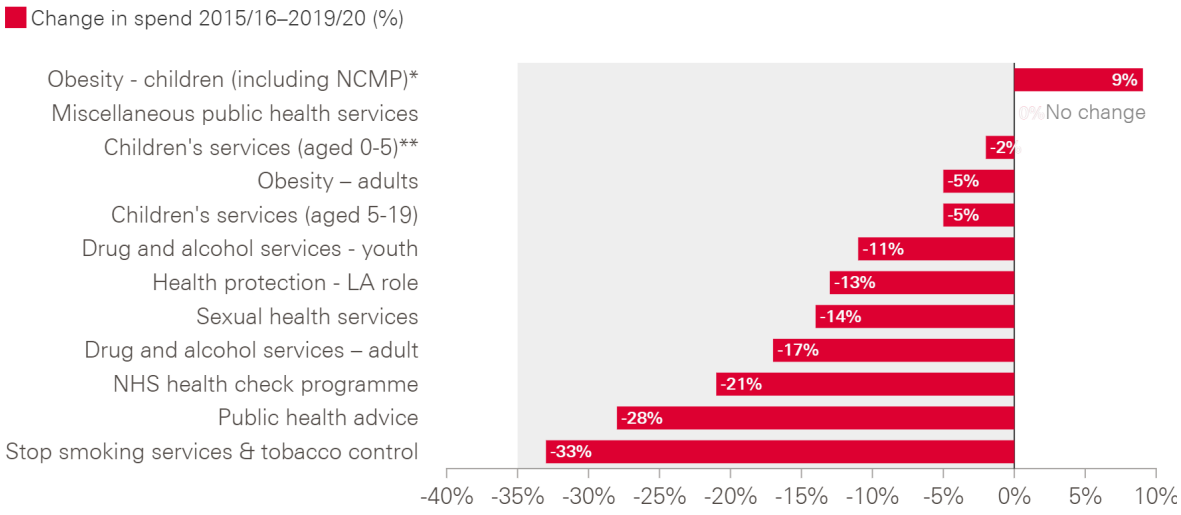
The grant is paid to local authorities from the Department for Health and Social Care (DHSC) budget. For 2021/22 the allocation for the public health grant was £3.3bn. However, there has been a 24% real-term per capita cut in the value of the public health grant between the initial allocations for 2015/16 and those for 2021/22.

The public health grant has been significantly reduced since 2015/16

Figure 1 shows how the reduction in grant allocations had fed through into spending on different elements of public health provision. It shows the change in spending between 2015/16 and 2019/20 (the latest out-turn data available). This expenditure does not necessarily match the total grant exactly, because councils may either underspend or spend from outside of the grant.

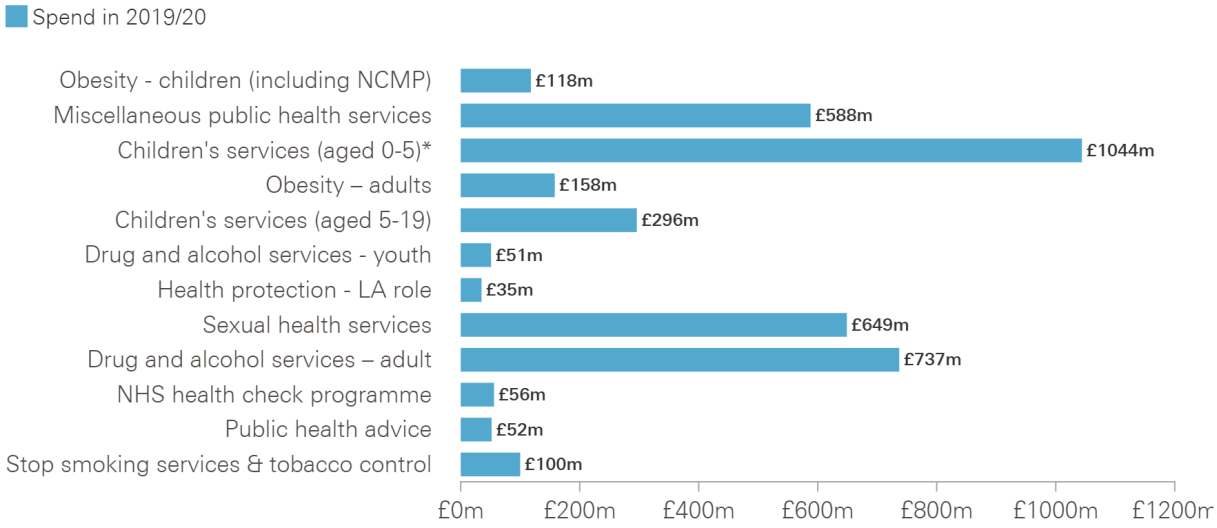
Most spending was on services for children aged 0–5 years – which is largely health visitors for infants and mothers (£1bn), drug and alcohol services for adults (£0.74bn) and sexual health services (£0.65bn). The greatest reduction in spending over the period was for smoking cessation services and tobacco control, which fell by 33% in real terms – yet smoking is by far the biggest risk factor ill health and early death in the UK. The one area in which spend increased was in obesity services for children.

Figure 1a – Percentage change in local authority public health spend since 2015/16 by element of provision, England, 2021/22 real terms (GDP deflator)



Source: Health Foundation analysis using MHCLG, Local authority revenue expenditure data, various; OBR, Economic and Fiscal Outlook, March 2021. • * NCMP is the National Child Measurement Programme. ** Period of comparison starts in 2016/17, the first full year in which this support was part of the public health grant.

Figure 1b – Local authority public health expenditure since 2015/16 by element of provision, England, 2021/22 real terms (GDP deflator)



Source: Health Foundation analysis using MHCLG, Local authority revenue expenditure data, various; OBR, Economic and Fiscal Outlook, March 2021. • * period of comparison starts in 2016/17, the first full year in which this support was part of the public health grant. NCMP is the National Child Measurement Programme.

As well as the large reductions in the grant, a lack of certainty makes it difficult for local authorities to effectively plan and implement services to best improve health. Public health grant allocations have been made just before the start of the financial year for the last 2 years, and with no clear multi-year plan.

Unmet need

Prior to the pandemic, trends in many indicators of underlying need for the services provided by the public health grant have continued at historic levels, or have increased:

- Rates of obesity for adults in England increased by 2 percentage points in 5 years to reach 28% in 2019, with the largest increases among under 16 to 44 year olds.
- Alcohol-specific death rates in England and Wales were 11 per 100,000 people in 2019, a slight increase from 10.6 per 100,000 people in 2014, but a 22% rise compared with 2009.
- Drug-related death rates in England and Wales have increased by 29% between 2014 and 2019, following a long-term trend of increasing at around 4% a year over the last 20 years.
- Sexually transmitted infection diagnosis rates in England had remained at around 800 per 100,000 of population over the last 5 years, increasing to 830 per 100,000 in 2019, driven by an increase in chlamydia and gonorrhoea diagnoses.

Smoking rates have reduced in England, falling from 17.9% to 13.9% of adults between 2014 and 2019. However, across the UK as a whole they have fallen by less among people older than 35, and the difference in smoking prevalence widened significantly between those in routine and manual occupations and those in other occupations between 2012 and 2019. People in routine and manual occupations are nearly 2.5 times more likely to smoke. So while current strategies to reduce smoking have led to a large fall at the population level,

these inequalities in rates urgently need to be addressed with many still in need of support to stop smoking.

The full impact of the pandemic on each of these indicators is not yet known, but there are early indications that some may have worsened and inequalities increased. The Health Profile for England 2021 reports that:

- The numbers of 'increasing and higher risk' drinkers increased in April 2020, remaining above pre-pandemic levels into the summer of 2021.
- There was a reduction in physical activity levels particularly among minority ethnic communities and people with lower socioeconomic status.
- More people are trying to stop smoking, with more than one in three smokers reporting attempts to quit in the 3 months to June 2021. However, there are also reports of increases in smoking among young adults during the first lockdown and during 2021.
- The impact of the pandemic on obesity in children and adults is not yet known, although previous research links time out of school in the holidays with weight gain in children. Given the changes in physical activity, diet and alcohol, it is possible that inequalities in obesity rates will have widened.
- Measures taken during the pandemic resulted in a drop in the number of people accessing sexual health services. But it is unknown how much of this is due to reduced infection rates and/or undetected infections, with reduced contact with health services during the pandemic.

Looking ahead, child poverty rates – used to indicate need for children's services such as health visitors – are projected to rise, with more than one in three children expected to be living in poverty by 2024/25. This is partly due to the end of the £20 uplift to Universal Credit, but also due to the continued bite of historic cuts to social security, including the two-child limit and benefit cap.

Local area reductions in the public health grant

Poor health is strongly associated with living in deprivation. There is a nearly 20-year gap in the years of good health a girl born in the most deprived 10% of areas can expect to live, compared with a girl born in the least deprived 10% of local areas.

However, cuts to the grant have been greater in more deprived areas. Figure 2 shows the real-term per capita cut in public health grant allocations between 2015/16 and 2020/21 and the deprivation score in each local authority. It shows that per capita reductions in the public health grant were greatest in more deprived areas. In Blackpool, ranked as the most deprived upper tier local authority in England, the per capita cut to the grant has been one of the largest, at £43 per person per year. Ambitions to 'level up' health will be undermined if this trend is not reversed.

Figure 2 – Real-term per capita change in public health grant allocations by local authority and deprivation rank: England, 2015/16 to 2021/22

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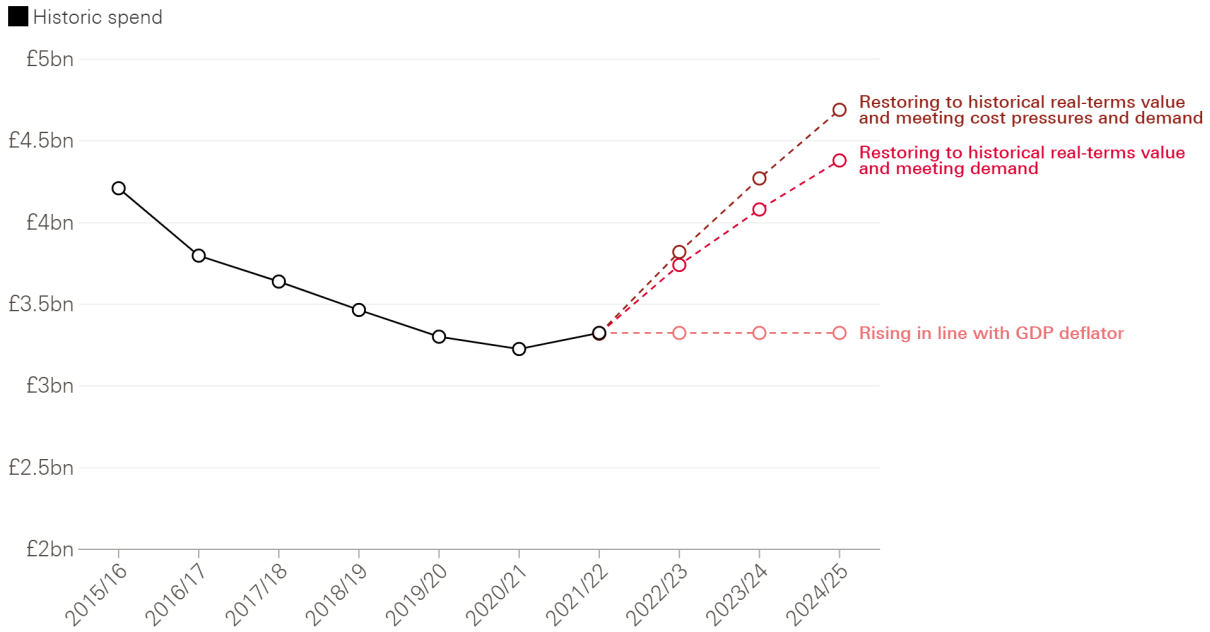
Source: DHSC, Public Health allocations, various; OBR, Economic and Fiscal Outlook, March 2021; MHCLG, English indices of deprivation 2019; ONS, Population estimates – local authority based by single year of age 2015 and 2019. • Note: Population used for per capita calculation is those aged younger than 75 in each local authority.

Reversing cuts and tracking future demand

By taking into account trends in population growth, need and cost of provision for elements of the public health grant, we are able to estimate a future path of spending that would help to ensure the grant keeps pace with demand and supports recovery from the pandemic. We assume that the cost of service provision reflects 70% wage costs (using Office for Budget Responsibility projections of average wage growth) and 30% general price inflation (GDP deflator) in line with the approach taken in wider projections related to NHSE spend and costs set out in the Personal Social Services Research Unit's annual unit cost estimates.

We estimate that to also restore the public health grant to its historic real-term per capita value and accounting for both cost pressures and demand levels would require an additional £1.4bn a year in 2021/22 price terms by 2024/25, the final year of this Spending Review. Taken together, these imply an average growth rate in the public health grant of 14% a year for the next 3 years. Figure 3 sets out the path of historic and projected spend. Beyond the Spending Review period, the public health grant should increase at least in line with NHSE spend to ensure it is prioritised relative to NHS spend.

Figure 3 – Historic and projected spend on the public health grant in different scenarios: England, 2015/16 to 2024/25, 2021/22 real terms



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Source: Health Foundation analysis using Ministry of Housing, Communities & Local Government, Local authority revenue expenditure data, OBR, Economic and Fiscal Outlook, March 2021.

Value for money

Local authority public health interventions funded by the public health grant provide excellent value for money. Research shows that the cost of each additional year of good health, using quality-adjusted life years achieved in the population by public health interventions, is £3,800. This is significantly lower than the cost of £13,500 per additional year of good health resulting from NHS interventions.

Failing to invest in the public health grant is a false economy. Investment in public health now to increase healthy years of life can help to reduce future pressures on the NHS, by focusing on improving health and wellbeing in later life and not just extending years of life. Postponing ill health until later in life through preventative action also has wider social and economic benefits both for individuals and society.

A review of research by the University of Cambridge, commissioned by the Health Foundation, has found a considerable evidence base demonstrating the effectiveness and cost-effectiveness of public health and preventative interventions.

Not all public health interventions are equally effective or cost-effective though. Furthermore, they have different impacts on health inequalities: some may reduce the gap in health, while others may inadvertently increase inequalities. Local public health teams should use this evidence about effectiveness and cost-effectiveness, together with their knowledge of their local population and needs, to determine the best combination of services to improve health and reduce inequalities in their areas.

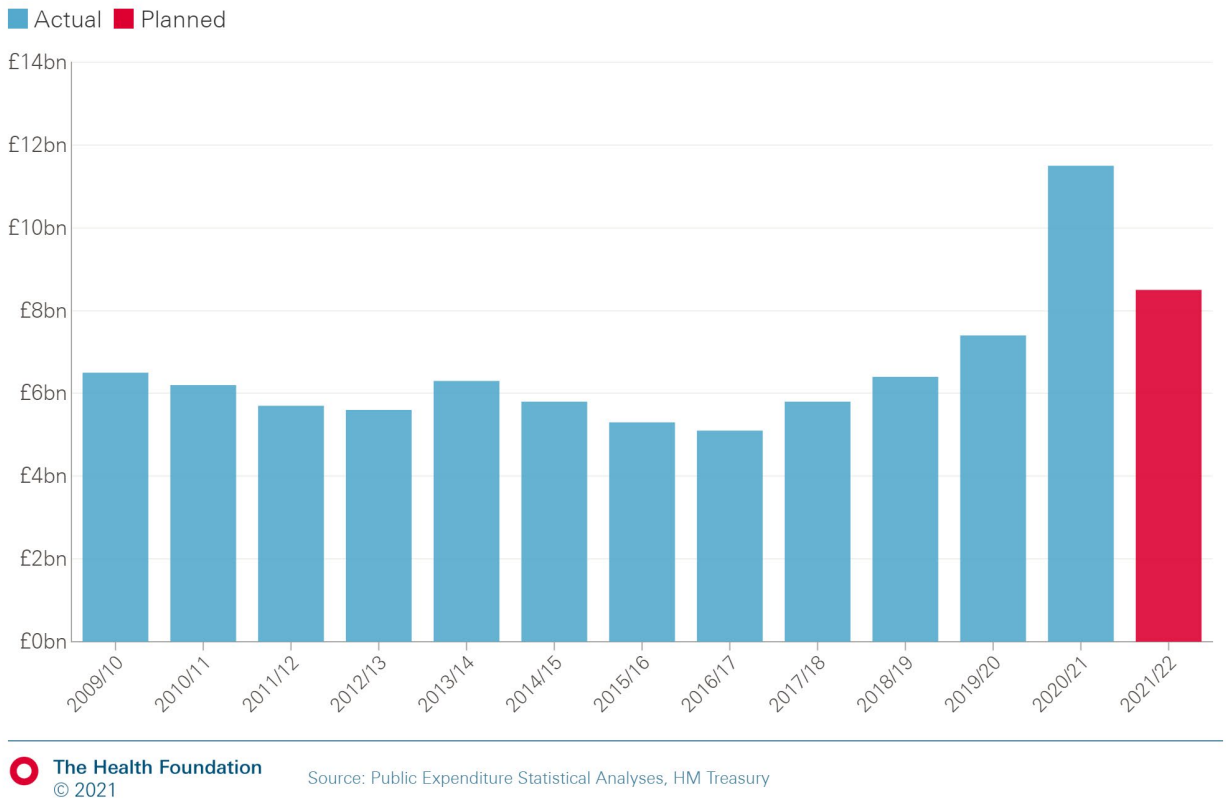
DHSC capital budget

The capital budget of the Department of Health and Social Care (DHSC) is used to finance long-term investments in the NHS in England. Capital investment plays a crucial role in delivering a safe, resilient and effective health care service. This includes ensuring that existing infrastructure is fit for purpose; that capacity matches the health needs of the population, both in the short- and long-term; and that capital investment improves the productivity of the NHS and supports the adoption of cost-effective interventions.

The current DHSC capital departmental expenditure limit (CDEL)

During the 2010s, investment in health care capital didn't keep pace with day-to-day spending. DHSC CDEL in 2018/19 was lower in real terms than in 2009/10. More recently, the budget has increased. DHSC CDEL in 2021/22 reached £11.5bn (in 2021/22 prices), but part of this was extra funding committed as part of the government's response to COVID-19. Planned funding in 2021/22 is £8.5bn according to this year's Public Expenditure Statistical Analyses (down from the £9.3bn announced in the March Budget).

Figure 4 – DHSC capital departmental expenditure limit (£bn, 2021/22 prices)



The government has committed a further £1.1bn, £1.2bn and £1.8bn for 2022/23, 2023/24 and 2024/25 as part of a multi-year settlement for the hospital building and upgrades programme. The multi-year settlement is welcomed, but the additional funding may not be on the scale needed to meet the funding pressures outlined below.

Pressures on DHSC capital budget

We have identified several outstanding pressures on the capital budget, including:

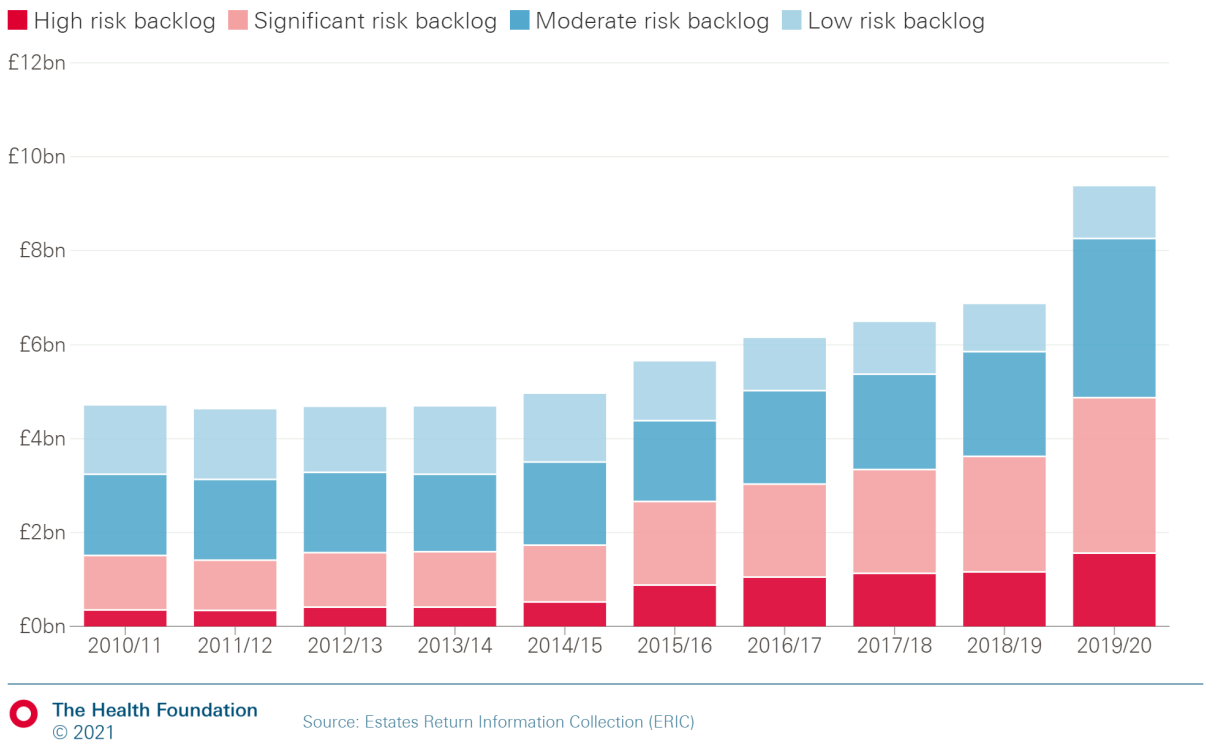
- a maintenance backlog, following relative underinvestment in DHSC capital budget
- an immediate increase in demand associated with attempts to clear the care backlog
- a projected increase in demand for beds associated with an increase in admissions in the coming decade
- a pressure to adopt cost-effective technologies to deliver a more efficient service.

A sizeable and growing maintenance backlog

One consequence of the relative underinvestment in the DHSC CDEL during the 2010s is a growing maintenance backlog, which in 2019/20 stood at £9bn.

£4.9bn of this is classified as 'significant' or 'high' risk. This means repairs or replacements are required either to avoid 'undue concern to statutory enforcement bodies or risk to health care delivery or safety' (significant risk) or 'in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution' (high risk). In short, to ensure the NHS is delivering a safe service, this backlog requires immediate and urgent attention.

Figure 5 – NHS maintenance backlog (£bn, 2021/22 prices)



Recovering from the COVID-19 pandemic

Following the COVID-19 pandemic there is a backlog of care needs. The waiting list stood at a record 5.6 million as of June 2021. In addition, elective care referrals were up to 8 million lower than expected. As these missing patients present themselves, the waiting list is expected to grow further. To clear the backlog in this parliament, we estimate it could require up to £17bn and almost 800,000 additional admitted patient pathways each year.

As the government has recognised, increasing care to treat these missing patients means delivering significantly more tests and scans, for which one limiting factor is diagnostic equipment. We estimate that returning to the waiting times standard could require more than 36,000 extra Computed Tomography (CT) scans per year. There are limited international data on which to base a comparison, but the UK is estimated to have a much lower level of, for example, CT scanners than international peers such as France and Germany. Another limiting factor is beds. Meeting the waiting times could require an extra 5,000 beds. The independent sector may be able to support some of this, but more NHS beds are still needed.

Meeting future demand pressures

After decades of a falling number of NHS beds, the Health Foundation's REAL Centre projects growing demand for inpatient hospital treatment over the next 10 years. Just considering underlying pressures (not including, for instance, the elective care backlog), we estimate the number of elective admissions could grow by 2.5% a year on average between 2018/19 and 2030/31, with non-elective admissions growing 2.6% per year over the same period. This demand reflects a growing and ageing population, with a higher level of morbidity, and more deaths in the coming decade.

The pressure on beds associated with increased admissions depends in part on what happens to the average length of stay. This has fallen over time, but there are signs this decrease is levelling off. Without a further sustained fall in length of stay, we estimate the number of NHS beds required in England will have to increase significantly over the coming decade. Moreover, just delivering the beds needed to meet demand would not improve the resilience of the system. To improve the resilience of the system by reducing bed occupancy to 85%, in line with clinical guidance, would require a still more sizeable increase. Although there is the potential for new technologies to increase productivity, we think this is going to be a significant pressure in the years ahead.

Delivering a more productive service

Higher productivity is crucial to meeting future care needs. For example, achieving 1.1% growth in cash-releasing productivity savings was a commitment in the NHS Long Term Plan. A higher rate of capital per worker is generally viewed to be a positive contributor to productivity. This is because workers can perform their work more efficiently when they have more capital (such as machines). Similarly, the Carter review into variation in the efficiency of acute hospitals noted that trusts view capital investment as a contributor to cost savings, but only in the long term.

However, for most of the 2010s capital per worker fell. Qualitative research commissioned by the Health Foundation found that many trusts viewed capital funding constraints as having a direct negative impact on their ability to deliver optimal care. Staff reported negative effects on productivity from issues such as equipment shortages and failure. Ageing diagnostic equipment in some hospitals negatively affected the ability of clinical staff to perform their work. The research also identified the built environment as having negative effects on patient care and safety.

Modern technology has the potential to increase productivity within the NHS. For example, digital technology and artificial intelligence may reduce the burden on staff through the automation of repetitive tasks. While the government has committed to a more technologically-driven NHS, buildings should also be a focus for improving productivity in

hospitals. Buildings that have been well designed can not only improve productivity (for example, by reducing walking times) but also provide a better overall working environment for staff.

Projected funding needs

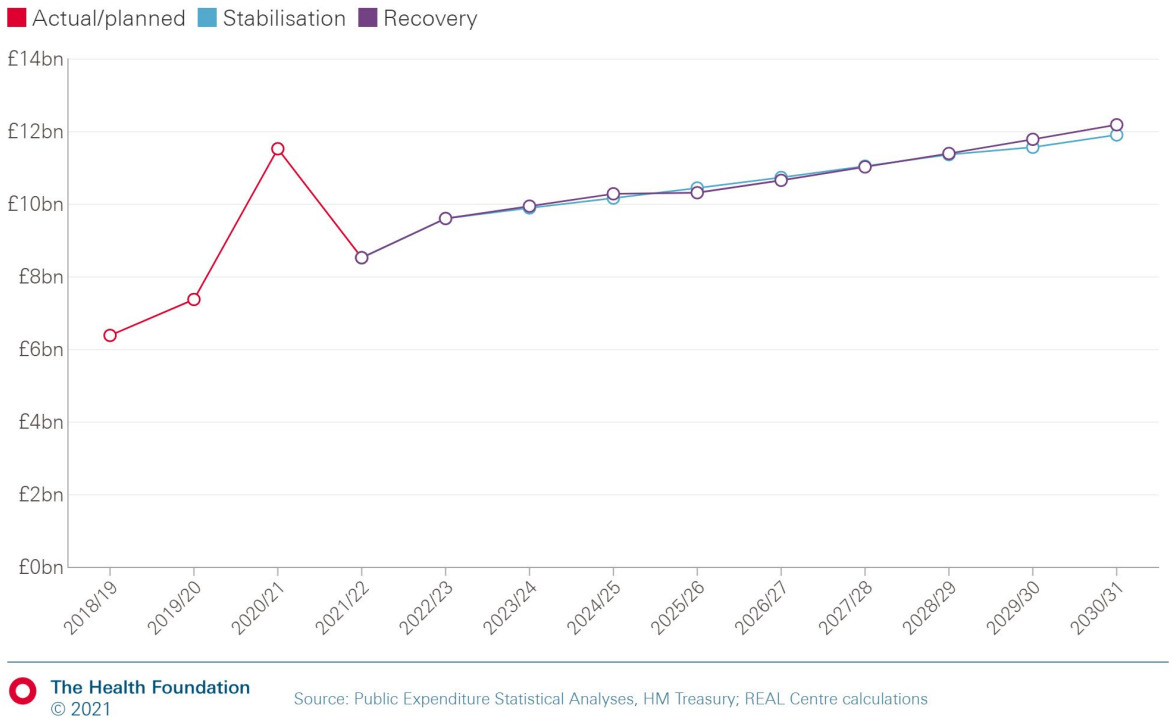
To meet these pressures, we project that – at a minimum – the capital budget would need to grow in line with current plans (note, our estimates use planned spend from this year's Budget) and then continue to increase in line with the wider NHS budget. We model two scenarios for spending growth: one where the system is stabilised after the pandemic and the other more ambitious scenario where services are recovered to NHS constitution standards and the NHS backlog is met during this parliament. Under either scenario, we project DHSC CDEL would need to be more than £10bn in 2024/25, rising to around £12bn in 2030/31. This represents growth of at least 6.0% a year in real terms between 2021/22 and 2024/25.

Table 1 – Projected DHSC CDEL (£bn, 2021/22 prices)

£bn (2021/22 prices)	2018/19	2024/25	2030/31
Stabilisation	6.4	10.2	11.9
Recovery	6.4	10.3	12.2

Source: REAL Centre calculations

Figure 6 – Actual, planned and projected DHSC CDEL (£bn, 2021/22 prices)



However, this figure of £10bn–£12bn is a minimum. We would highlight two areas of uncertainty where there is potential additional upward pressure. One is COVID-19: further

adjustments to the NHS estate may support the NHS to cope with pressures in the short to medium term. Another is demand for beds: this is an area in which the REAL Centre will be doing further modelling.

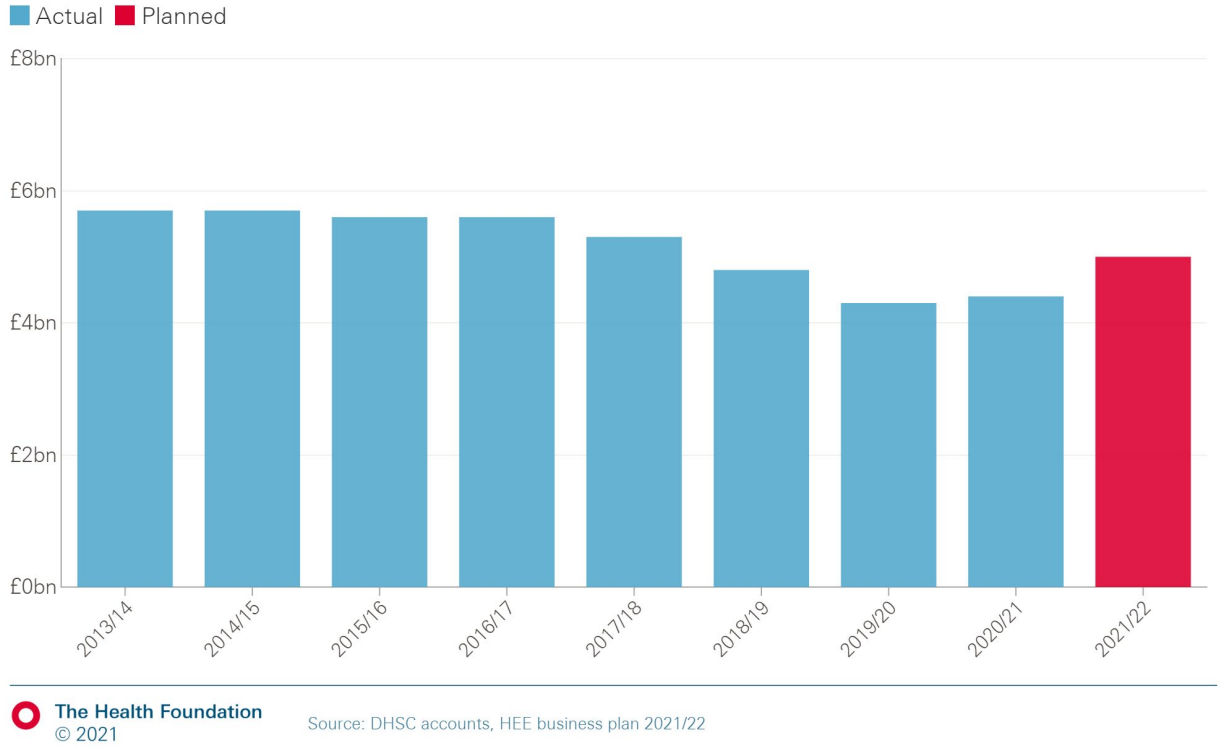
Workforce and Health Education England

The workforce is the most critical input for delivering health and care. Prior to the pandemic, vacancies were growing. Looking ahead, with demand expected to increase, the health and social care workforce could need to grow by as much as a million staff by 2030/31. This includes a 40% increase in the health care workforce, more than double the growth for the NHS over the last decade. To deliver this, it is crucial to recruit and train workers – this takes time and it is important this starts now.

The current Health Education England budget

According to the 2021/22 business plan, the Health Education England (HEE) budget in 2021/22 will reach £5bn. This represents a substantial increase from the 2020/21 budget (14.3% real-terms growth). Specifically, the 'Future Workforce' budget grew by £480m in 2021/22, which can help sustain increases in trainee numbers.

Figure 7 – Health Education England budget (£bn, 2021/22 prices)



Pressures on HEE budget

We have identified several outstanding pressures on health care workforce and on the HEE budget. These include:

- current workforce vacancies
- workforce shortages to meet an immediate increase in activity associated with COVID-19 and attempts to clear the care backlog

- projected workforce shortages resulting from increased demand in the coming decade.

Current vacancies

According to current workforce statistics from NHS Digital, there were more than 90,000 vacancies in the hospital and community health services workforce in Q1 of 2021/22, although this is down from more than 100,000 prior to the COVID-19 pandemic.

By sector, workforce shortages are particularly high for acute care and mental health. Looking by role, there were nearly 40,000 registered nurse places unfilled, accounting for 42% of all vacancies (while registered nurses account for around a quarter of the hospital and community health service workforce). This highlights that nursing continues to be the most pressing area of NHS workforce shortages.

Previous Health Foundation research emphasises that in nursing, undergraduate nurse education is the most prominent supply channel. In 2020 there was a 23% increase in the number of students accepted onto nursing degree courses in England (relative to 2019) – the highest annual number of acceptances since 2011. Sustaining this increase will be key to achieving the government's target of 50,000 nurses by the end of the parliament. That calls for sustained increases in HEE funding and policy action, not only on increasing domestic supply but also on improved retention and international recruitment. We estimate that the government will need an average of 5,000 international recruits a year up to 2024/25.

Supporting the recovery from the COVID-19 pandemic

There are likely to be additional workforce demands associated with the post-pandemic recovery. The government has assigned additional funding to meet the elective care backlog. While we estimate the funding falls short of the £17bn needed to return to the waiting times standard within this parliament, a significant increase in activity will be required to deliver 30% more pathways by 2024/25. We estimate that meeting the backlog by 2024/25 could require as many as 18,000 additional nurses and more than 4,000 extra consultants.

Table 2 – Estimated additional staff required

Extra staff needed	Returning to 2018/19 levels of performance (2021/22 to 2028/29)	Meeting the RTT target (2021/22 to 2024/25)
Consultants	2,270	4,440
Nurses	9,370	18,310

Source: REAL Centre calculations; note, this assumes 75% of missing patients return.

Meeting future demand pressures

Beyond the immediate post-pandemic pressures, REAL Centre projections suggest a sustained and sizeable increase in the workforce is needed in the decade ahead to meet care needs.

We estimate that demand pressures, including commitments under the NHS Long Term Plan and meeting the backlog of care needs after the pandemic, could require a health care workforce that is 488,000 (40%) larger in 2030/31 than in 2018/19. Demand is particularly high for acute care, but we estimate that a significantly larger primary care, community care and mental health workforce is also required.

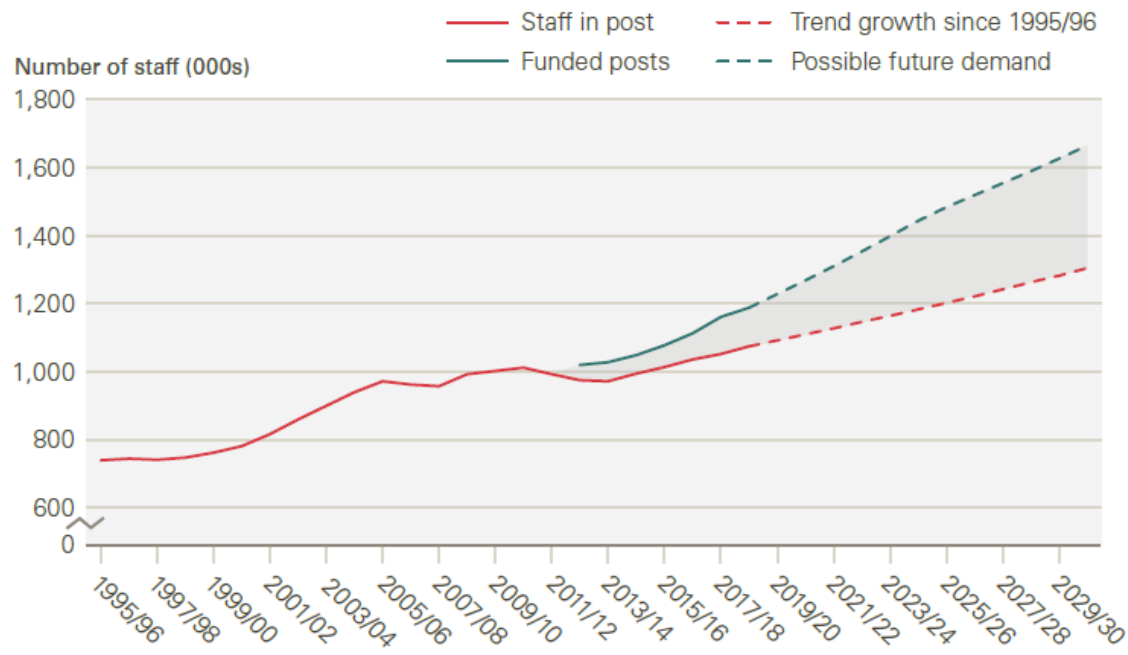
Table 3 – Workforce projections

Area	**2018/19**	**2024/25**	Extra FTE	% change	**2030/31**	Extra FTE	% change	CAGR* (2018/19-2030/31)
Health care	**1,225,000**	**1,500,000**	*275,000*	22%	**1,713,000**	*488,000*	40%	2.8%
Of which:								
Doctors	**147,000**	**180,000**	*34,000*	23%	**205,000**	*59,000*	40%	2.8%
Nurses	**306,000**	**375,000**	*69,000*	22%	**429,000**	*122,000*	40%	2.8%
Social care	**1,130,000**	**1,447,000**	*317,000*	28%	**1,757,000**	*627,000*	55%	3.7%
Of which:								
Local authority	**92,000**	**117,000**	*26,000*	28%	**143,000**	*51,000*	55%	3.7%

Source: REAL Centre calculations.
*Note: doctors and nurses include both acute staff and those in primary care; nurses include health visitors. * CARG = Compound annual growth rate.*

Productivity gains may be labour saving, thereby allowing the same activity to be delivered with a lower growth in the workforce, but the scale of this increase suggests substantial increases in staffing will be needed. Based on trend growth in staff places, we estimate there could be a shortfall of staff of 360,000 full time equivalents (FTEs) by 2030/31.

Figure 8 – Comparison of health care workforce projections with trend growth in posts



Source: NHS Digital; REAL Centre calculations.
Note: projections for hospital and community health services workforce.

Projected funding needs

Meeting these challenges will require action on every element of workforce supply: training, retention and overseas recruitment.

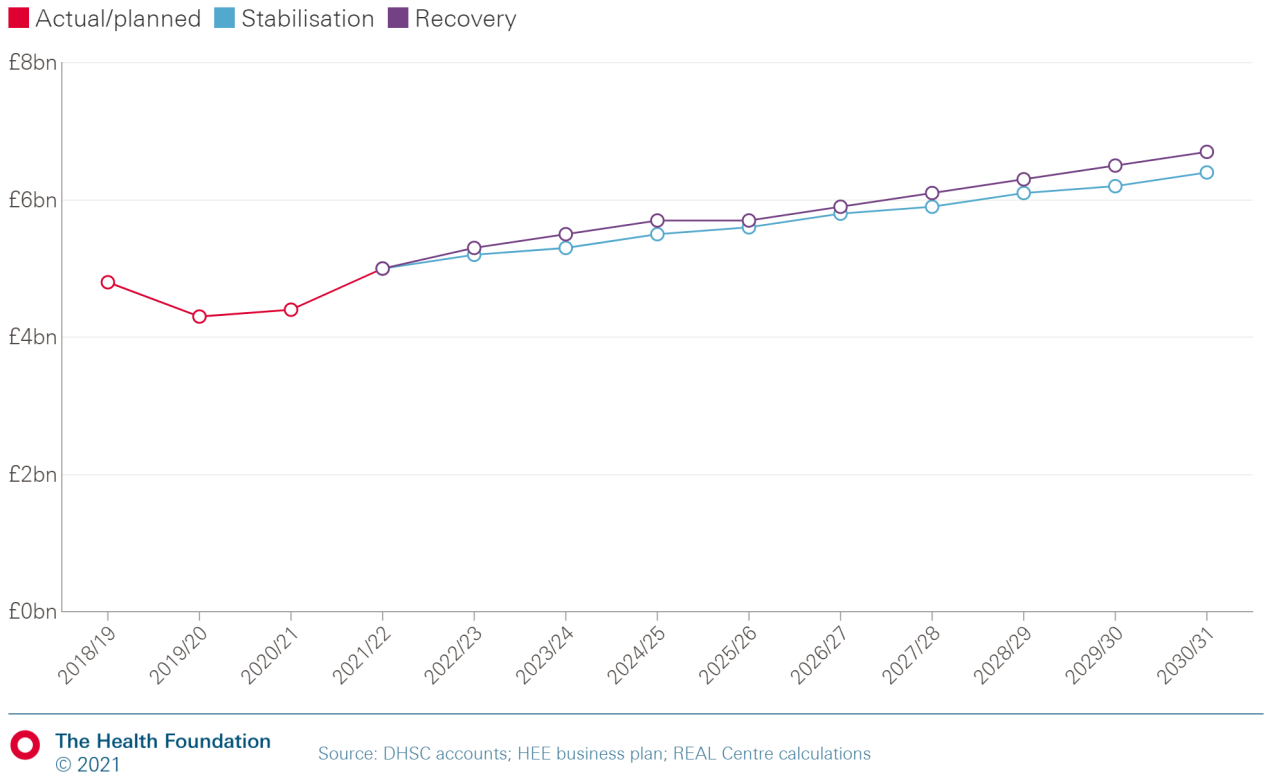
To support this, the HEE budget needs to keep pace with growth in the wider NHS budget. Under either scenario projected by the REAL Centre, we estimate the HEE budget would need rise to at least £5.5bn in 2024/25 and continue to increase to more than £6bn in 2030/31. This equates to growth of 3–4.1% a year in real terms between 2021/22 and 2024/25.

Table 4 – Projected HEE budget (£bn, 2021/22 prices)

£bn (2021/22 prices)	2018/19	2024/25	2030/31
Stabilisation	4.4	5.5	6.4
Recovery	4.4	5.7	6.7

Source: REAL Centre calculations

Figure 9 – Actual, planned and projected HEE budget (£bn, 2021/22 prices)



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Source: DHSC accounts; HEE business plan; REAL Centre calculations

Social care

The Health Foundation welcomes the government's recent announcement of some important reforms to adult social care in England, supported with additional funding. The cap on care costs is a positive step forward which, if implemented well, will protect people against catastrophic costs, provide greater certainty about the future costs they need to plan for and help reduce the care cost lottery.

The extent to which the cap will achieve its aims and protect everyone against catastrophic costs depends on several parameters which have not yet been confirmed – for example, how much individuals in residential care would need to contribute to general living costs. A cap of £86,000 is relatively high and means that those with modest assets and high care needs will still risk losing a high proportion of their wealth in future. This should be considered in the process of confirming the remaining details of the system.

Although the reforms to how social care is paid for are welcome, they will not be enough to deliver the prime minister's promise to 'fix social care'.

We have written extensively on the other, wider challenges facing social care – including in our submission to the Health Select Committee inquiry into Social Care Workforce and Funding – and what should be done to address them. These challenges include increasing numbers of people unable to access social care, systemic and significant workforce problems, variability in the quality of care that people receive, and many care providers at risk of collapse.

The recently announced reforms and funding do not address these problems. Once funding for the cap on care costs is taken into account, we estimate that the recent announcement provides at most around £1.5bn a year to 2024/25 – compared with the £2.5bn needed just to meet demand and the £9.3bn needed to meet demand, sustain and improve the current system.

We are encouraged that the government has committed to bring forward a White Paper on reforming adult social care later this year. As the government develops this, its priorities should include:

- increasing access to care and better meeting growing need for care in the future, as people live longer and the number of people with disabilities rises
- better meeting people's needs by improving the quality of care that people receive, including by ensuring integrated social care and NHS services meet the needs of the individual, and enabling more innovative approaches to care
- developing a comprehensive, fully costed workforce strategy that both tackles urgent problems with availability of staff and plans for the future, and better rewarding and supporting social care staff and unpaid carers
- advancing data and analytics to fill gaps in our knowledge about people who need and use care services, and those who provide them, in order to better shape services for the future.

Significant additional funding will be required to deliver the comprehensive reform which is needed. The scale of this partly reflects a decade in which social care spend has failed to keep up with demand and cost pressures. Table 5 shows recently published REAL Centre estimates of the funding needed to stabilise and improve the current system (and estimates

of the increased size of the workforce required are shown in Table 3). Our previous research also includes a wider range of scenarios and further detail on the basis for these estimates. We have also set out the likely benefits of additional funding and associated evidence.

The additional funding needed for adult social care should be considered within the context of the overall settlement for local government. Even though funding over the last decade has been flat in real terms (compared with a 20% increase in NHS funding), adult social care services have been relatively protected as local authority budgets have been reduced. If wider local government finance pressures are not met, any increased funding earmarked for adult social care is less likely to lead to an equivalent increase in the overall budgets for adult social care. This is because core adult social care budgets are not ringfenced. This is a problem which has occurred historically with the adult social care precept, where some councils who used the flexibility to increase council tax to fund adult social care services have not increased budgets by an equivalent amount.

Additional funding needs to be secure and long term so that councils, providers and others in the sector can plan for the future, encourage innovation and not just spend more on the same. Beyond the new Health and Social Care Levy, there are a range of options for raising additional funds.

Table 5 – Projected adult social care spending (£bn, 2021/22 prices)

		2021/22	2022/23	2023/24	2024/25
Current spending power (excluding one-off COVID-19 funding)	£bn	20.1	20.3	20.5	20.7
	Annual real-terms growth rate	0.6%	0.9%	1.1%	1.0%
Stabilisation	£bn	23.1	24.0	24.7	25.5
	Additional funding (compared with current spending power, £bn)	3.0	3.7	4.2	4.8
	Annual real-terms growth rate	8.6%	3.6%	3.2%	3.2%
Recovery	£bn	27.2	28.2	29.1	30.0
	Additional funding (compared with current spending power, £bn)	7.1	7.9	8.6	9.3
	Annual real-terms growth rate	17.4%*	3.6%	3.2%	3.2%

Source: REAL Centre calculations.
*Notes: Figures are for England. Annual real-terms growth rates are relative to the previous year. *Fast increase is driven by the projected increase in social care package and staff pay.*