Briefing: The social care funding gap: implications for local health care reform

Key points

- The visible squeeze on NHS funding has added a powerful urgency to local plans to reform health and care services, known as Sustainability and Transformation Plans (STPs).
- The 44 STPs across England bring together a coalition of local hospital, primary care and social care bodies to think collectively about how to respond to the challenges of a growing and ageing population. The plans contain ambitious proposals to close the gap between demand and available funding by improving the prevention of ill health; making more efficient use of hospital and specialist care; and delivering care closer to people's homes whenever possible.
- Successful implementation of these plans will require a robust social care sector. Six years of real-terms reductions in social care budgets have left 400,000 fewer people receiving essential help, as well as destabilising the providers of care, leading to some going out of business. Social care is essential for people to lead as independent a life as possible, and to ensure they can be moved out of hospital safely and quickly.
- Our analysis of STPs suggests that the funding gap for adult social care is at least £2bn in 2017/18. This figure is in line with other estimates.
- Many of the STPs include proposals to improve the care of older people, often requiring effective and accessible social care.
- We interviewed local STP leaders and found that the size of the social care funding gap identified in the STPs may be an underestimate. They also reported that, while health and social care were working well together in some areas, in others the social care funding situation was creating strain in the relationships between sectors.
- So far, the government has allowed local authorities to raise additional funding through a new council tax precept and committed an additional £1.5bn of central funding for social care by 2019/20. However, this is insufficient to meet the rising needs of the social care system, and the benefits will not be fully realised until the end of the parliament.
- The 2017 budgets need to provide significant additional funding for social care to ensure proper support for those people and their families who are struggling to manage, and to protect the NHS from inefficiency.

The Health Foundation

Introduction

The financial pressures being experienced by the NHS in England are severe and mounting. More than half of NHS trusts are in the red and NHS providers are forecasting a total overspend of £873m* for 2016/17.[1] For the public, the collision of rising need and stagnating funding is now clearly visible in overloaded emergency departments, cancelled operations and longer waits for treatment across England.

As NHS hospitals and other providers grapple with the challenge of keeping front-line services running, the government is hoping that Sustainability and Transformation Plans (STPs) – local reform plans designed by the leaders of hospitals, local authorities and other NHS bodies – will create a less turbulent and more sustainable path for health and care services in the future. The 44 STPs are moving towards implementation across England and are designed to restore financial balance to the NHS at the same time as improving care. The plans contain ambitious proposals to improve services, including prevention of ill health, more care closer to people's homes and more efficient use of hospital services.[2]

Central to these plans is the idea that local health and social care organisations think collaboratively about their budgets and the services they offer to their populations. But there is an imbalance at the heart of the STPs: the scale and impact of the cuts to social care services, particularly for older people.

This briefing offers an analysis of the size of the gap in social care funding through the lens of the STPs, and sets out the implications of this for health and care reform plans if the social care funding gap is not adequately filled.

* Please note: All financial data in this briefing have been adjusted to 2016/17 prices using HM Treasury's gross domestic product (GDP) deflators published on 6 January 2017.

What's happened to social care?

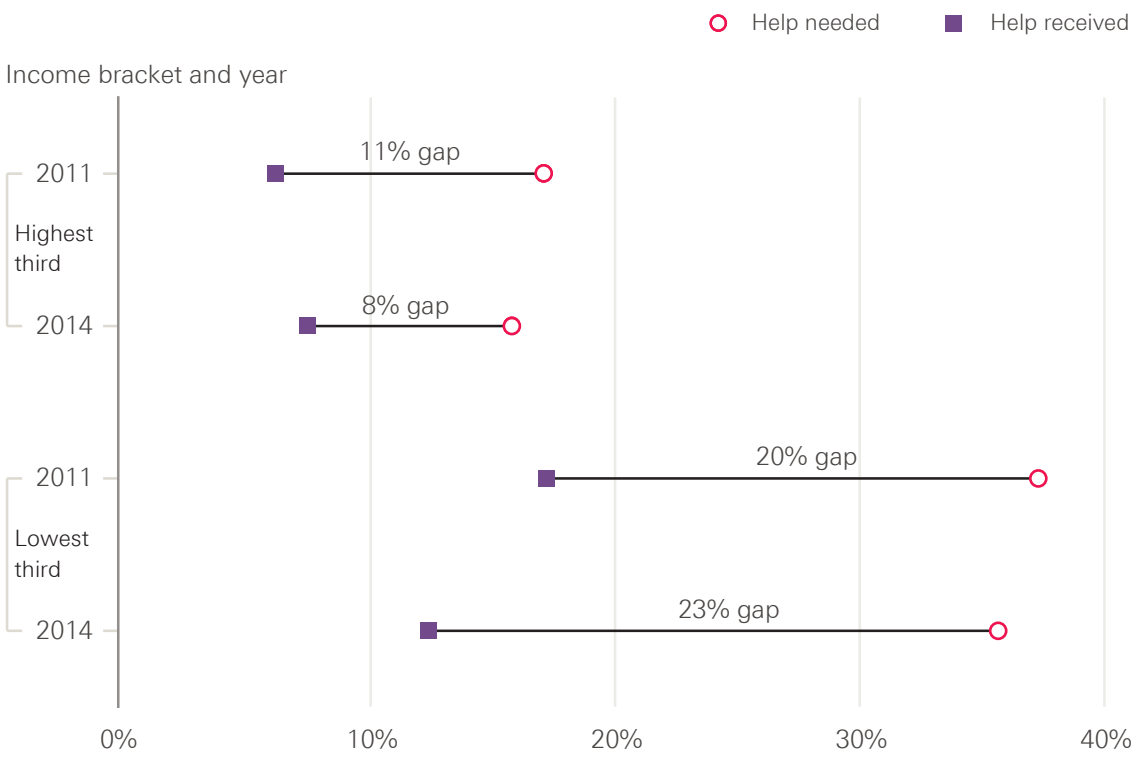
For hundreds of thousands of people, social care – help with everyday tasks of living – has a vital but unsung role. It keeps people independent in their own homes for longer, can help them regain their independence after illness and, where home is no longer an option, residential-based social care provides a safe place for people to live.

Social care for both working age and older people has been under financial pressure in recent years, but some of the biggest reductions have been made to the support for older people, those on low incomes and those with high care needs. For these groups, funding has been dropping steadily since 2010.[3] Public spending by local authorities on adult social care has fallen for six consecutive years, and by 9% in real terms between 2009/10 and 2014/15.[4] Over 400,000 fewer older people were able to access publicly funded social care in 2014/15 compared to 2009/10 – a drop of 26%. In 2015/16, the number of people aged 65 and over living in England increased by 2% (around 170,000 people), yet the number of them receiving social care has fallen by 2%, with around 12,000 fewer older people accessing long-term support in 2015/16 than in 2014/15.

For people no longer eligible for publicly funded social care, this means managing on their own – using their own money or family and friends for help, or in worst cases, receiving no support at all. The percentage of people whose family is buying additional care or support privately increased from 9.5% to 10.4% between 2014/15 and 2015/16.[5] In addition to fewer people receiving care, reduced funding is also impacting on the nature of care provided to those still in the system. The dwindling number of people getting publicly funded help often experience shorter visits from care workers and need to pay higher contributions or 'top-up fees' from their own resources.[6] As local authorities have tried to focus spending on the most vulnerable, there have been deep cuts to community services – such as transport and social activities – that play an important role in preventing isolation and related ill health.[7] At the same time, NHS services that aid people living in their own home have been reduced; for example, the number of district nurses fell by 44% between 2009 and 2016.[8] The recent national audit of intermediate care also suggests that current spending on intermediate care is around half what is needed to meet demand.[9]

This unmet need has enormous costs, both human and financial, for individuals and their families and carers. In addition, it is not evenly distributed across the population (see Figure 1 overleaf), with the gap between need for and receipt of help with activities of daily living (ADLs) being far greater among those in the lowest income bracket (the bottom third) than those in the highest. Furthermore, this gap has been rising for those with the lowest incomes, and falling for those with the highest incomes.

Figure 1: Change in gap between need for and receipt of help with activities of daily living (ADLs), 2011–2014[10]



Note: Activities of daily living include eating, bathing, dressing. Figures may not sum due to rounding.

The cuts to social care have also had profound impact on the providers of social care – both those running residential care homes and those providing care in people's own homes. Many local authorities have been forced to manage the cuts to their own budgets by reducing the fees paid to social care providers. This has led to many providers passing on higher costs to people who pay for their care privately, as well as taking on rising levels of debt, with some providers going out of business.[11,12]

How has the government responded to the social care problem?

The following sources of additional funding for social care were announced in the 2015 Spending Review:[13]

- A social care precept that enables local authorities to increase council tax by up to 2% a year between 2016/17 and 2019/20 to raise funds for social care.
- An 'improved' Better Care Fund (BCF), including an additional £1.5bn a year in cash terms (£1.4bn in real terms) provided by 2019/20. However, this will not begin to come through until next year, with £105m provided in 2017/18 and the full amount of £1.5bn not delivered until 2019/20.

The 2015 Spending Review also set out plans for significant reform of local government finance: grant funding for local authorities is being reduced by £6.1bn by 2019/20, but local government will be able to retain all income generated locally from business rates. However, this policy has potential implications for equity, with wide disparities across the country in the ability of local authorities to generate income from business rates. This is particularly important given the inequalities in unmet need for social care, as those areas with least potential to raise funding are likely to be those with the most unmet need. Some of this disparity will be rebalanced by targeting the new BCF funding where need is highest, although the full benefit of this will not be realised until 2019/20.[14]

The provisional local government finance settlement for 2017/18, announced in December 2016, included further measures impacting on social care funding. These are:

- increased flexibility of the social care precept to enable councils to bring some of the funding forward by raising council tax by up to 3% in 2017/18 and 2018/19 (on the condition that there is no further increase in 2019/20)
- a new one-off grant for adult social care providing £240m to local authorities in 2017/18.*

In 2016/17 all but eight councils raised additional funding for social care through the precept.[15] The Local Government Association (LGA) reported that 147 out of 151 councils in England are expected to levy the 3% precept in 2017/18. This is expected to raise £543m for social care. However, the 'national living wage' will rise to £7.50 an hour in April 2017 and this will increase costs for social care providers. The LGA estimates the living wage will add £970m to the yearly cost of publicly funded social care in England.[16]

Between 2014/15 and 2020/21 social care funding is estimated to increase by around 1% a year in real terms,[4] assuming that councils also take advantage of the full 3% precept in 2018/19, thus halting the trend of previous funding cuts between 2009/10 and 2014/15. However, the pressures on social care services are rising – partly from increasing need as the population ages but also as costs increase from the 'national living wage'. This represents significant challenges for social care providers, whose financial model can be very fragile. Research suggests that pressures on the service are increasing by over 4% a year above inflation – three times the rate of funding growth.

* This funding is redirected from the New Homes Bonus, so it does not represent additional funding for local authorities.

Will the new money be enough to fill the social care funding gap?

A number of organisations have estimated the potential funding gap for social care. However, these are estimates for England as a whole. There are 44 STP areas (footprints) within England and each has produced a plan with the aim of improving health care, based on the specific needs of their area. These plans include measures to integrate health and social care. Although STPs were not required to include information on the social care gap and interventions to address this gap, 25 of the 44 STPs have quantified a social care funding gap. These estimates are based on local analysis of the needs for social care based on the communities served, the local social care market and the changes planned to the health service. We have extrapolated these estimates to produce a total for the social care funding gap for England. STPs are publicly available from NHS England.[17] The sum of the estimates reported by the 25 STPs who identified a gap, and estimates extrapolated for England as a whole, are shown in Table 1.

We calculated the populations for the estimates reported by STPs using Office for National Statistics population projections by local authority, linked to STPs by local authority codes.

We calculated the extrapolated figures in two ways:

- population mean gap per head for people aged 18 and over*
- population median† gap per head to account for outliers.

Both methods estimate that the social care funding gap is expected to increase from around £2bn in 2017/18 to over £4bn in 2020/21. Full details of our methods are available in the accompanying technical appendix.‡

Table 1: Social care funding gap for England, extrapolated from estimates reported by 25 STPs, real terms (2016/17 prices)

	2017/18	2020/21
Social care funding gap in 25 STPs	£1.2bn	£2.5bn
Estimated social care funding gap for England using the population mean (2016/17 prices)	£2.1bn	£4.4bn
Estimated social care funding gap for England using the population median (2016/17 prices)	£2.0bn	£4.4bn

* These figures were extrapolated to the whole population of adults in England (aged 18+) using the following formula for the mean population value estimates:

$$\textit{Extrapolated social care gap} = \frac{\textit{(Value of social care gap as reported by 25 STPs * adult population of all 44 STPs)}}{\textit{Adult population of 25 STPs who reported gap}}$$

† Median population estimates were calculated by ranking STPs and their respective populations by the size of reported social care funding gap and calculating the cumulative population. Where the median person fell, the gap value from this STP was multiplied by the total population of adults in England to extrapolate the funding gap.

‡ Available from www.health.org.uk/social-care-and-STPs

To measure how representative these 25 STPs are of all 44 STPs, we tested for differences in indicators related to the social care funding gap.* We explored three measures of need: the number of low income pensioners, the number of pensioners who had health issues that made them eligible for the attendance allowance benefit, and the number of pensioners living alone. We also examined whether the STPs reporting a social care funding gap had lower spending on social care, a different pattern of delayed transfers of care from hospital (DTOCs), or the ability to raise funds through the social care precept in 2016/17. Crucially, there were no statistically significant† differences across any of these indicators for local authorities in STPs who reported a gap, compared to those who did not. We therefore concluded that the 25 STPs reporting a gap are broadly representative of the whole of England, allowing us to extrapolate a total estimated gap.

It is important to note that this estimated figure is not necessarily calculated using a consistent approach across all STPs. However, the estimate from this analysis – around £2bn for 2017/18 – is broadly consistent with other estimates of the gap. For example, a November 2016 briefing by the Health Foundation, Nuffield Trust and The King's Fund estimated a gap of £1.9bn for 2017/18, rising to £2.3bn by the end of this parliament.[4]

Table 2 shows a number of estimates of the scale of the funding challenge facing adult social care, with a gap ranging from £1.6bn to £1.9bn for 2017/18. Even the most optimistic of the estimates represents a funding gap of one-tenth of the current budget.

Table 2: Estimates of the funding gap for adult social care – people aged 18 and over unless specified

Source	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Health Foundation, The King's Fund and Nuffield Trust[4]	–	–	£1.9bn	–	£2.3bn	–	–
ADASS[18]	–	£1.4bn	£1.6bn	£1.4bn	£1.1bn	–	–
Local Government Association (LGA, 2016)[19] (cash terms)	–	–	–	–	£2.6bn	–	–

* As it was not mandatory for STPs to report their funding gaps, information on the methodology of calculating the gaps was not reported. We have therefore taken these figures at face value, and they should therefore be treated with caution.

† With 5% confidence – see technical appendix for more detail: www.health.org.uk/social-care-and-STPs

These estimates are based on maintaining the current threshold and quality of service. They don't include additional cost pressures from addressing the backlog of needs among people who previously would have been eligible for care. Nor do they account for additional investment that may be required to stabilise the current system, which is seeing more providers struggle to offer services at prices paid. They also don't reflect new ways of meeting the needs of older people by bringing together health and social care. However, this is at the heart of many STPs, building on the vision for the health and care system set out in the NHS's *Five year forward view*.[20]

In 2020/21, the funding gap for social care in England, based on the estimates provided by the 25 STPs, would rise to £4.4bn (in 2016/17 prices). This is higher than other estimates for the period, which are closer to around half of this value (see Table 2). It is important to note that the methodology for calculating the gap may not be consistent across all STPs. For example, we have not been able to determine the extent that additional funding from the social care precept and costs from the new living wage have been included. Equally, we are unable to determine whether the estimates by STPs include additional investment for unmet need, or to stabilise current providers who are struggling to meet cost pressures. These factors may explain the higher estimate.

Of the 25 STPs who reported a social care funding gap, 18 also suggested that a potential £1.1bn of offsetting savings may be achieved for social care by 2020/21. If offsetting efficiencies of a similar magnitude were possible across all 44 STPs, then a best-case scenario might see the total social care funding gap fall to £1.5bn by 2020/21. However, it is important to note that: we do not know the extent to which these savings would require additional investment in other services; some of these efficiencies might be double counting income measures such as the precept; and it is not certain whether achieving savings of this scale is possible within three years. In addition, even this best-case scenario represents a funding gap worth around £1 in every £10 currently spent on adult social care.

What is the impact of the social care funding gap on plans for local health and care reform?

To understand the implications of the social care funding gap on the new models of care and plans for local health and care reform, we reviewed a sample of the STPs that estimated a funding gap for social care. We also conducted interviews with senior STP health and social care leaders. We selected interviewees to reflect a range of geographies and both high and low levels of detail on social care within their STPs, as well as high and low levels of delayed transfers of care (DTOCs). In this section we include a selection of quotes from interviewees.

The importance of social care to STPs

One common aim of STPs is to reduce demand on an overstretched acute sector and find other ways to support people in their own homes or outside hospital. For older people, who are increasingly likely to have care needs, any solutions are likely to involve social care services. In turn, these will depend on a healthy social care market with a strong workforce.

> 'Our entire system is predicated on the ability to move people efficiently and effectively through a care system. Without a core strong social care system, that becomes nigh-on impossible.'

Despite this, only 25 of the 44 STPs formally state their social care funding position. Given that the plans were devised by the NHS, rather than by branches of government responsible for social services, this is perhaps not entirely surprising. Just four of the 44 original STP leads were from local authority/social care and some local authorities' discontent with the process was made visible by the premature leaking of plans in autumn 2016.[21]

But where STPs directly discuss social care, the lack of funding is seen as a key risk to the plans to reform the health and care system. These include risks to hospital efficiency through DTOCs and potentially avoidable emergency admissions to hospital. Risks to new models of care also arise because the precarious state of the social care provider market is threatening plans to support people in non-hospital, lower cost environments.

What would investment in social care deliver?

Delivering the ambitions of the *Five year forward view* requires fundamental changes to the way services are provided. STPs are central to doing this and social care involvement is essential if they are to succeed. New models of care need to be created that cross traditional organisational boundaries and focus on preventing ill health and deterioration of illness, delivering care closer to people's homes and streamlining hospital services. The ambition in many STP areas is for health and social care providers to come together to deliver such services under one capitated budget (budget per head of population).

The STPs include projects to transform services by bringing health and social care teams together to provide services across their geographical footprint. These are based on best practice both in the UK and internationally and aim to shift focus from care being provided unnecessarily in hospitals towards supporting citizens in the community (see Table 3). We also heard discussion of these approaches in our interviews.

Table 3: New models of care for health and social care systems

Improving care in the community

- **Integrated community multidisciplinary teams:** Teams centred around primary and community services that focus on preventing avoidable admissions and providing care closer to home through multidisciplinary needs assessment and care planning/delivery.

  These teams use risk stratification tools to identity those with the most need. Having social care professionals as members of the team is crucial to ensure the full care needs of the patients assessed are understood and planned for.

- **Domiciliary workforce development:** Developing the skills of domiciliary care workers in the community to improve continuity of care and coordination for patients, as well as enabling the care workforce to provide a broader range of care support. This reduces the burden on community nursing and avoids duplication. In some areas this draws on learning from the Buurtzorg model of care.[22]

- **Enhanced health in care homes:** Enhanced provision of health care in care homes, following good practice from vanguard sites in the new care models programme.[23]

  This includes aligning primary care teams with care homes and increasing the frequency of rounds to assess the needs of patients. This requires sustained engagement from care home managers and staff to prepare for, participate in and implement actions following the visits, working closely with the clinical teams, residents and their families. It therefore requires a stable workforce and sufficient care home provision.

  Other service developments include improving the process for when residents do require emergency admission – including ensuring immediate and enhanced information is provided to hospitals to improve residents' care while they are a hospital inpatient, decreasing their length of stay.

Better transitions of care and recovery

- **Improved hospital discharge and reablement:** Bringing social care discharge coordinators from local authorities to work with hospital ward teams to ensure that the most appropriate care packages are discussed at an early stage with patients and their families.

  This supports early identification of patients who need care packages and ensures that the most appropriate reablement approach is put in place. It avoids unnecessary discharge delays and maximises patients' chances of avoiding readmission.

- **Improved community bed-based care:** Models that improve the coordination of care between hospital care, short-stay intermediate care beds and care at home. This includes multidisciplinary rounds from health professionals and social workers working with patients and their families to ensure patients are being provided with care in the most appropriate setting for their needs.

  An important element in this process is the provision of short-stay intermediate care beds, which, through the delivery of rehabilitation and social support, help to improve a patient's independence, thus reducing their long-term care requirements. The availability of intermediate care beds and staff are crucial for this.

Providing crisis support and preventing unnecessary hospital admission

- **Rapid response crisis and recovery services:** Rapid response services in the community that prevent those with long-term health needs going into hospital and supports those recently discharged from hospital with their recovery.

  These teams usually respond within four hours, 24 hours a day, to provide assessments and put in place immediate crisis support. They then work to coordinate a longer-term plan for these patients. Social workers are core to these teams, as is the flexibility in the domiciliary care sector to provide increased support at short notice to prevent hospital admission.

Worryingly, some interviewees suggested that the figure for the social care funding gap included in their STP was likely an underestimate or, at best, based on the optimistic assumption of maintaining current levels of care rather than meeting future demand in 2020/21. Some interviewees reported that they felt local authorities in their area may have underplayed the scale of the gap for fear of political repercussions, or used reserves to conceal the real scale of the shortfall.

> 'It's a gap that is masked to a degree by both planned and unplanned use of council reserves.'

Another common theme in the interviews was the impact of wider cuts to local authority services. A 37% reduction in funding to local government over the past six years[24] means that many local authorities have been forced to scale back community-based prevention schemes or reduce spending on sectors, such as housing, that are important determinants of health.*

> 'The preventative services, carer support services, they're getting squeezed. That's harder to map in terms of direct consequences, but it's going to have an impact.'

The sharp increases in DTOCs have been reported as an obvious symptom of pressure on social care. But low rates of DTOCs in an area do not signal the absence of a social care problem. A senior leader from an area with some of the lowest DTOCs in the country attributed this to a surplus of care home beds due to a depressed property market. This meant a better performance than in other localities within their STP on delayed transfers, but they were concerned about emergency admissions rising because of lack of care in people's homes.

> 'In terms of delayed discharges we've always been quite low… but here the impact now is at the front end, so people going in to hospital. Just because they've got no other mechanism of support closer to home. We have increasing A&E attendance, and a higher than you'd expect level of admissions.'

The limitation of DTOC figures only reflecting the 'back door' of the acute sector was discussed by all those we spoke to. They were clear that the social care position contributed to the 'front door' of emergency hospital admissions but described the challenges in capturing this accurately due to the difficulties in assessing unmet social care needs (eligible or ineligible), data availability and linking data.

Impact on plans for transformation

Our interviewees saw a well-funded social care sector as vital to improving services, rather than just standing still. Additional funding for transformation was described as essential for scaling and spreading improvements, such as the examples presented in Table 3.

> 'If we had more investment we could deliver the smarter solutions faster at much more pace…'

> 'We're trying to make all these things happen, but they're at a micro level rather than macro. They're small scale and they're slow. What we'd do if we had some more money is that we'd upscale it, we'd do it faster and far more comprehensively than we're able to do currently.'

* For more details on determinants of health, see: www.health.org.uk/publication/healthy-lives-people-uk

But STP leaders acknowledged that there was an immediate need to stabilise the social care position before some of the more ambitious plans could be realised. Recent use of BCF money to cover existing deficits rather than enable transformation was a theme brought out in our interviews. In addition, a recent National Audit Office report found that, of the £2.1bn NHS Sustainability and Transformation Fund for 2016/17, £1.8bn was allocated to covering NHS deficits rather than transformation.[25]

> 'Here in (…) actually that resource is needed to support the adult social baseline, so in effect through our BCF at the moment, health is putting £8.5m into the adult social care baseline to keep the current service going.'

Adequate funding will also take time to reverse the damage done by consecutive years of cuts to provider fees and the impact on the social care workforce. STP leaders spoke of care home providers handing back contracts and closing beds, and of the extreme difficulty of finding domiciliary care providers, particularly in rural areas.

Prospects for future joint working

The financial crisis has effectively brought health and social care together in some STPs.

> 'I've worked [here] for 20 years and I've never seen us so aligned as we are now. If you're all looking over the same cliff edge into the abyss, you have a different set of conversations.'

But in other areas, the pressures were leading some organisations to act in isolation. For example, we heard that, where there had been a lack of collaboration between health and social care partners, some NHS-led discharge to assess and care brokerage schemes were leading to unhelpful competition over prices, beds and domiciliary care within a limited provider market.

> 'I think that we've seen lots of differential policies around things like discharge to assess that have been well meaning but tactical rather than collectively strategic.'

Some interviewees told us health care organisations were reluctant to come together with social care in joint financial arrangements, because they did not want to take on further financial risk in addition to their own deficits. We heard of new organisational models that had stalled or stopped due to such risks.

Overall, the senior STP leaders we spoke to were clear that without a significant funding increase the social care position is unsustainable.

> 'We're all looking over the same cliff edge. Some organisations might go over the edge marginally before others, but even if one of the smaller organisations went over, the impact on the rest of the system is huge and then we'd all go over together.'

Conclusion

The very visible stresses in England's A&E departments and hospitals have captured the attention of the public and politicians over the past few months. There is growing awareness that the ragged state of social care is playing an important role in those pressures.

Viewing the importance of social care through the lens of potential impact on delivery of STPs, as we have done in this briefing, is only part of the story. The government needs to fill the social care funding gap, first and foremost, because it is the right thing to do for all the people who otherwise struggle to live their lives with even a minimum of dignity and independence. It is an essential service in its own right.

But it is also inescapable that the impact of the social care funding gap has started to bleed out across the wider system, and that much-needed changes to the NHS will be almost impossible unless that gap is addressed. Six years of cuts to local authority budgets have been managed by reducing fees to social care providers, resulting in an increasingly indebted and unstable provider market. Added to this are workforce pressures: the introduction of the 'national living wage' is vital to improve the working lives of care workers but will not immediately reverse the problems that providers have had in recruiting and retaining staff to care for an increasingly frail population. Providing social care is demanding work for comparatively low wages.

The vision contained in many STPs – of much more effort on preventing ill health and deterioration of illness, of care delivered closer to people's homes, of streamlined hospital and specialised care delivered to the right people at the right time – will be impossible without a vibrant social care sector. As we learned in our interviews and analysis of STPs, a starved social care sector has made collaboration and innovation very challenging across England.

Based on local STPs, social care faces a funding gap of £2bn in 2017/18. This is consistent with analysis from The King's Fund, Health Foundation, Nuffield Trust and ADASS. Despite the additional funding earmarked for social care from the council tax precept and BCF, there is a funding shortfall projected for the rest of this decade. Additional funding is needed urgently but that funding must also be sustained.

Any additional funding from government therefore needs to do two things. It must backfill the social care funding gap and restore support to the thousands of people who have fallen out of the public social care system. But it must also be sufficient to allow local authorities and social care providers to engage fully in the service redesign that's needed in local areas to underpin new models of care.

The gap in social care can no longer be ignored: it puts unacceptable pressure on those requiring care and their families, as well as on staff in both social care and the NHS. But it also risks unravelling the STPs and their ambitions to put health and care services on a more sustainable footing.

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