



briefing

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Papering over the cracks: the impact of social care funding on the NHS

Key points

- **Demand for health and social care will continue to rise**, particularly with the increase in the number of very old people and adults living with multiple disabilities. The population of over-65s is projected to grow by 50 per cent over the next 20 years. We must ensure that the health and social care system meets the needs of this growing demographic.
- Local authorities currently face huge financial pressures. When people's needs are not met by the social care system, they turn to the NHS. **This is not an issue for the future but for now.** Sixty six per cent of NHS leaders said that shortfalls in local authority spending had impacted on their services over the past year.
- There are large numbers of people who are experiencing delays in being transferred to the right sort of care. This has both a **financial and a human cost.** Delayed transfers in care currently cost the NHS £545,000 per day (approximately £200 million per year). They are distressing for patients and, without action, the situation will get worse.
- There are two key issues for the Government to address: **the current funding gap for social care** and the need to **implement a long-term solution.** In the last Comprehensive Spending Review, the Government allocated an extra £2 billion to social care by 2015. £1 billion of this was transferred from the NHS. We recognised this as a necessary 'sticking plaster' in the short term. However, the transfer did not represent a long-term solution. In many areas this money has had to be used to paper over the cracks in the system and local authorities have had to plan on the basis that this money will continue to be available. Without further action on funding, even the basic social care that we currently expect for the very old will not be available in the future from local authority-funded social care.
- **If the long-term funding challenges are not solved, the system will become unsustainable.** The Dilnot Commission's proposals are the most credible and practical solution on social care funding. The Government must commit to implementing them as soon as possible. It will cost £2 billion to implement the proposals. The Government must include these extra funds in the next Spending Review and clarify where it will find the money.
- **In the long term, it is not sustainable to expect the funding shortfall of £2 billion for social care to come from the NHS.** The NHS already needs to deliver an unprecedented level of efficiency savings with a budget which is essentially flat. To increase NHS efficiency savings by at least £2 billion a year on top of the Government's existing requirement to save £4 to £5 billion a year will not be possible without severely affecting patient care. We are calling for a cross-party consensus on solving the challenges raised.
- **The ambitions of the social care reforms will only be realised if the funding challenges are solved.**

Demand for both NHS and social care services is increasing rapidly, due to growing demographic pressure from an ageing population and an increasing number of people living with complex care needs. Funding is not keeping pace with demand.

This *Briefing* outlines the current demographic and financial realities of social care and how these impact upon the NHS. It shows the additional pressure that will be put upon the health and care system in the coming years; and it sets out the NHS Confederation's recommendations for a lasting solution for the funding of social care and a redoubling of efforts to integrate care. We are calling for a cross-party consensus on solving the challenges raised.

What is the demographic reality?

A huge and growing number of people need a large amount of care from both the NHS and social care. Demand for care will continue to increase, particularly with the growth in the very old and for adults living with multiple disabilities. For example:

- the population of over-65s is projected to grow by 50 per cent over the next 20 years
- the number of working age adults with learning disabilities will rise by around 30 per cent over the next 20 years¹
- in 2011 there were over 430,000 residents aged 90 and over in England and Wales compared with 340,000 in 2001 – a 21 per cent increase²
- more than 820,000 people are estimated to be living with

dementia in the UK³ and this is expected to increase to 1.7 million by 2050.⁴ The added pressure this puts on both the health service and social care providers is significant. More care is required and it is more stressful for both carers (paid and unpaid) and family members.

Figure 1 shows that the number of very old people is projected to rise rapidly over the next 20 years.

We should celebrate the success story that we are living longer. However, we also need to recognise the reality that with this success comes extra burdens upon health and social care services.

In addition, demand for local authority-funded social care services is also being driven by a decline in the capacity of many people to self-fund their care. This is as a result of the current economic situation.

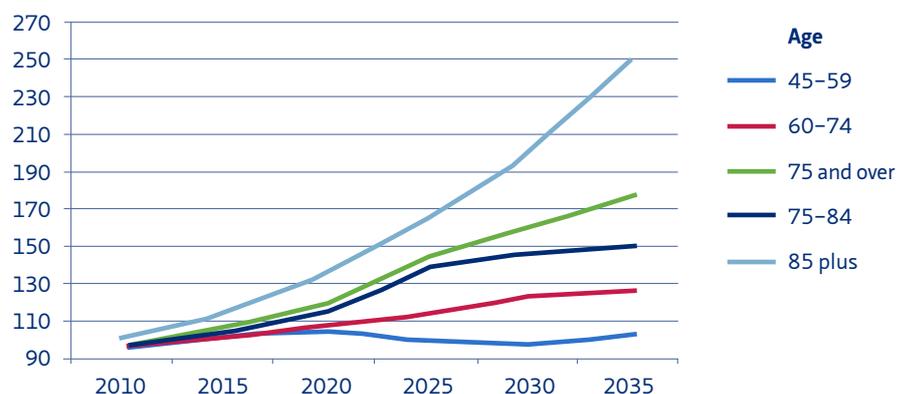
Figure 2 shows the connections between the intensity of people's use of social care and their use of NHS services. It shows that residents of care homes had fewer hospital admissions than those being cared for at home and that those who receive no social care have fewer hospital admissions. The evidence proves a clear link between care needs and the use of NHS services.

Can social care provision keep pace with rising demand?

Many local authorities' responses to the huge challenge of rapidly growing demand for social care and constrained funds have included restricting eligibility criteria. This means, in many areas, services are only provided to people who have the most severe care needs.

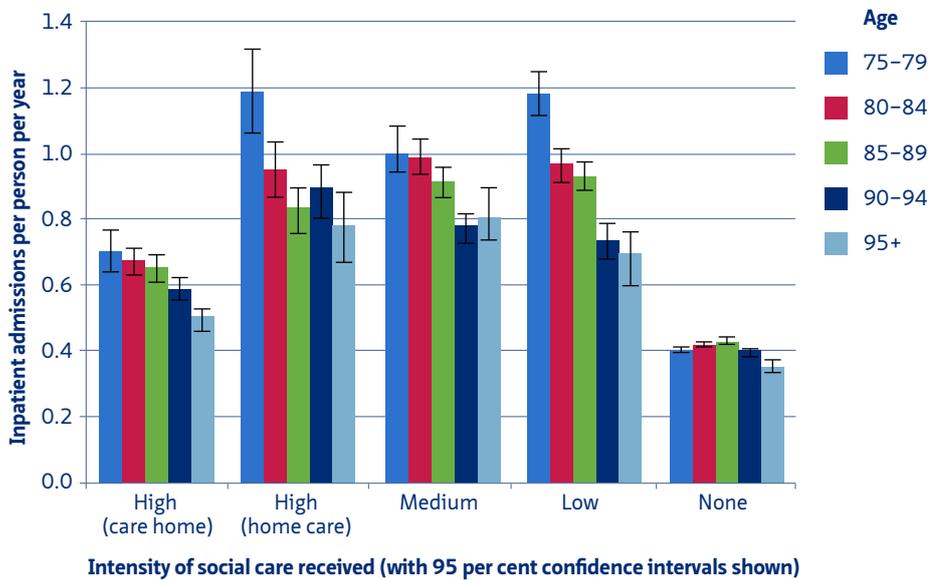
The Local Government Association (LGA) has stated that it expects a funding gap for local authority services of £16.5 billion

Figure 1. Projected population by age, United Kingdom, 2010–35 (2010 = 100)



Source: Office for National Statistics (Oct 2011) National Population Projections 2010-based Statistical Bulletin.

Figure 2. Number of inpatient admissions per person by age and type of social care received



Source: Charlesworth A and Thorlby R (2012), *Reforming social care: options for funding*. Nuffield Trust

impact in the form of increased demand for emergency and unplanned work, and delays in discharging people from hospital.

Delayed transfers of care already cost the NHS £545,000 per day (approximately £200 million per year.)⁷ We expect this to increase if social care provision is not adequate. The number of emergency admissions among patients aged 75 and over has increased by 18 per cent between 2006/07 (1.231 million) and 2010/11 (1.453 million).⁸

The results from a recent NHS Confederation survey of NHS chief executives and chairs found that 66 per cent said shortfalls in local authority spending had impacted on their services over the past 12 months.⁹ Of those respondents, 92 per cent said there were more delayed discharges from hospital; 87 per cent said there was greater demand for community services; and 57 per cent said there were

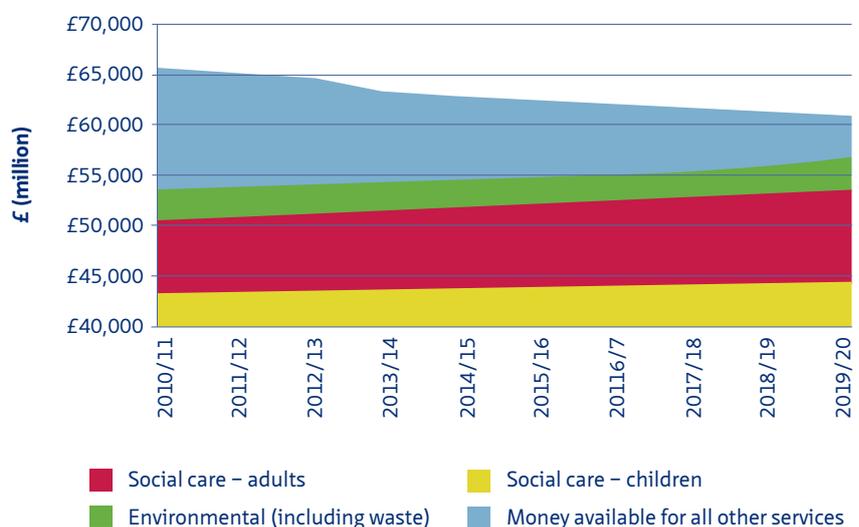
a year by 2019/20, or a 29 per cent shortfall between revenue and spending pressures.⁵ The LGA has estimated a future funding scenario with social care and waste spending (both of which are statutory obligations) absorbing a rising proportion of the resources available to councils, shown in Figure 3. The LGA's figures indicate funding for other local authority services will drop from £24.5 billion in 2010/11 to £8.4 billion in 2019/20, which would be the equivalent of an 80 per cent real terms cut.⁶

It is not clear whether a reduction in spending of this magnitude on other services is deliverable. We are concerned that, without action on both funding and integration, even the very basic social care that we currently expect for the very old and those with disabilities will not be available in future.

How do unmet social care needs affect the NHS?

When people's needs are not met by the social care system they turn to the NHS, which experiences the

Figure 3. Social care and waste spending within the overall funding envelope



Source: Local Government Association

more acute admissions to hospital. Healthcare leaders were clear that demands on the NHS will increase over the next decade. The most commonly cited challenges were care of the elderly (42 per cent) and pressure on finances (42 per cent).

These extra pressures come when the NHS is already under severe financial pressure. In its first Comprehensive Spending Review, the Government stated that the NHS would receive an average annual real terms funding increase of 0.1 per cent to 2014/15. This protection for the NHS budget is welcome and necessary. However, it does not take account of rising demand, inflation and rapidly increasing healthcare costs, particularly for new treatments and drugs, meaning the NHS needs to do much more with the money it has. The NHS is expected to make £20 billion of efficiencies by 2014/15, an unprecedented savings requirement that has not yet been achieved by any health service in the world, particularly one going through structural reform. This will require some very tough choices. Any

Case study: The view from a community provider

In Norfolk, the NHS is just starting to feel the impact of a tightening of social care budgets. Michael Scott, chief executive of **Norfolk Community Health and Care NHS Trust**, explains that his staff are starting to find themselves picking up new pieces of care work, such as making meals, that they have not had to do in the past and are not funded to do. He believes this is due to restrictions to care packages and the tightening of eligibility criteria.

Michael says: "The funding from the NHS has enabled my local authority to just keep up with demand. However, if a sustainable funding solution isn't found for social care, this will result in more older people ending up in more expensive care in hospital."

additional increases in demand due to social care services being unable to meet people's needs will exacerbate these pressures.

In the current NHS funding scenario, with inflation factored in, this results in a slight decline in real terms in years 2010/11 and 2011/12 and, after a small increase in the current financial year, a decrease in 2013/14.¹⁰

Has the extra money for social care worked?

In the 2010 Comprehensive Spending Review, an additional

£2 billion a year was allocated to social care by 2014/15, with £1 billion of this coming from the NHS. The aim of this funding was to secure delivery of care and transform services through re-ablement and other initiatives. In July 2012, the Government announced that an extra £300 million, over two years, would be found from NHS efficiency savings to support social care.

Recent evidence¹¹ (see Figure 4) shows that 64 per cent of the funds has been used for specific aspects of transforming care but we know that 18 per cent has been used to maintain the current level of social care provision for the increasing number of service users. The Government's figures show there is a significant variation in how different areas have used the funds. However, across the country, only 8 per cent of the funds was dedicated to hospital discharge initiatives, 18 per cent on re-ablement and 9 per cent on bed-based intermediate care services.

The NHS Confederation has supported the extra funding for social care. We recognise the extremely challenging financial

Case study: Unmet social care needs are affecting the NHS

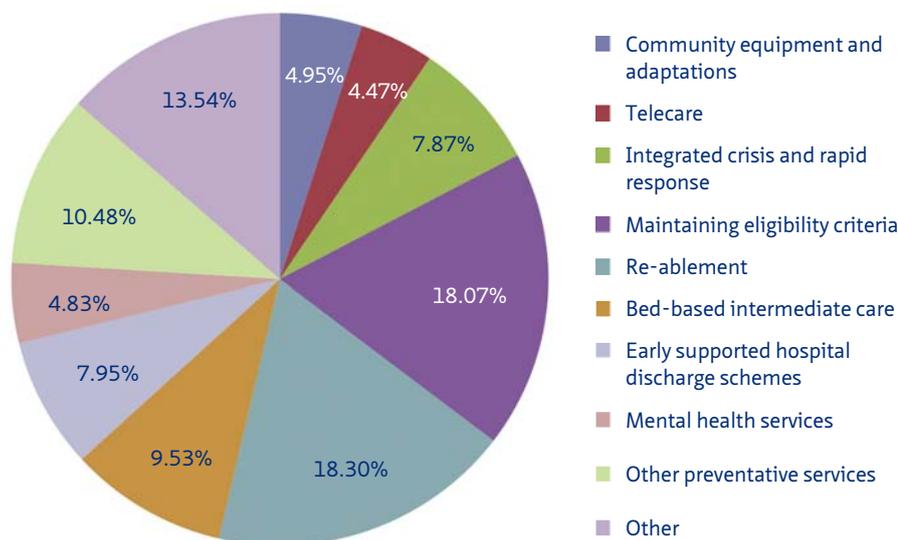
Mathew Winn, chief executive of **Cambridgeshire Community Services NHS Trust**, explains that the impact of increasing demand for social care and the cuts to the local authority's budget are resulting in:

- delays in handover from rehabilitation and intermediate health services to domiciliary care
- local authority overspends as a result of meeting their statutory responsibilities to meet demand and live within threshold protocols.

Matthew says: "We are planning for worsening scenarios. On top of the 4 per cent efficiency savings we have to make annually, we are having to plan to save another 3 to 5 per cent for the next two years just to keep up with demand for older people's services.

"The demographic evidence about increasing demand is clear – this is not an issue for the future, it is happening now."

Figure 4. Allocation of additional NHS resources by local authorities, 2011/12



situation facing local authorities. The transfer of funds from the NHS to social care has been crucial in many areas in ensuring there is sufficient social care provision to meet people’s needs.

However, we need to recognise that some areas have not been able to use the money taken from the NHS to pay for services to help tackle the need for intensive, expensive support. Instead, these funds have in many areas been used to paper over the cracks in the social care system. This risks storing up worse problems for the future.

Understandably, local authorities are now planning on the basis that they will have these funds and are becoming reliant on receiving this money every year. Any reduction in the funds available to them will make it even harder to meet people’s need for care, and could endanger services that local authorities and the local NHS have planned jointly. However, taking

funds from the NHS budget to fill the funding gap for social care should only be a temporary measure and should not continue in the long term. It will cost the Government £2 billion a year to implement the Dilnot proposals. However, it is not sustainable to expect the funding shortfall of £2 billion for social care to come from the NHS. It is not possible to increase NHS efficiency savings by at least £2 billion a year on top of the existing requirement to save £4 to £5 billion a year for at least the next four years without severely affecting care. The Government must include the extra funds required within the next Spending Review and clarify where it will find the extra funds needed whilst taking into consideration the impact this might have on other public sector budgets.

How should the NHS and Government respond?

Both greater funding and greater integration are necessary; neither

will be sufficient on their own in ensuring a sustainable social care system.

A long-term, sustainable solution is needed, which increases social care funding for the growing group of people who have increased needs. In addition, in the short and medium term, a sustainable funding package for social care is needed which does not stop at bailing out areas that are in crisis, but that also enables investment in services which will save money by improving people’s overall health and independence. The ambitions of the social care reforms within the Care and Support Bill will only be realised if the funding challenges are solved.

There is also widespread consensus that we need to make better use of resources and improve people’s experiences by ensuring more integration of care. Local authorities, NHS organisations, national organisations and government all have a role to play in ensuring we overcome the challenges in moving from aspiration to practical implementation of this aim.

Should we implement the Dilnot Commission’s funding proposals?

In the long term, the Dilnot Commission’s proposals, which would involve funding from both government and individuals, are the most credible and practical solution to social care funding for some time. As the problem is worsening, it is critical that the Government commits now to a clear implementation plan.

The Government's recent progress report on funding reform¹² stated that it "agrees that the principles of the Commission's model would be the right basis for any new funding model", but deferred a final decision on whether the main recommendations will be implemented until the next Spending Review period. Nonetheless, we are encouraged by recent reports in the media that the Government may look to mirror the Commission's proposals, potentially as early as this autumn.

We recommend:

- the Government commits both to implementing the Dilnot Commission's recommendations and to raising the additional central funding required, estimated by the Commission at £1.3 to £2.2 billion
- that any new proposals to use the NHS budget to help implement the Dilnot recommendations are carefully considered. As outlined above, the health service is already facing an immense financial challenge and adding additional savings to fund social care risks exacerbating existing pressures.

How can we get individuals to contribute?

Given the financial pressures we have outlined, self-funded care has an important part to play in any sustainable social care system. It is vital that the public faces up to the true cost of providing social care. The Dilnot Commission's proposals are the most practical and credible way of achieving this. Because the proposals would cap

the cost any individual would have to pay towards their care, their implementation would give individuals some certainty about their personal liability and better allow those who are able to, to plan how to meet the costs of care up to the proposed cap.

We stress that the Dilnot Commission's proposals are still complex in some areas – for example, on how accommodation costs would be paid. To ensure that the public have a good understanding of what they will need to contribute towards their care, **we recommend** that when implementing the Dilnot Commission proposals:

- politicians, the Government, NHS and local authorities are honest about the scale of contributions the public will be liable for in future
- the Government confirms as soon as possible the level of both the cap on the amount any individual can pay towards their care costs and the asset threshold above which an individual must pay their entire residential care costs themselves
- the system is designed in such a way that the different rights and responsibilities of individuals and organisations within health and social care are clear to the public
- the Government acts on the Commission's recommendation for a national awareness campaign once a new model for funding and structuring social care is agreed on
- clear information is made widely available, so people can make provision.

The Government's progress report on social care funding states that, from April 2015, "no-one will be forced to sell their house in their lifetime to pay for care". A national scheme of deferred payments for residential care (currently only available in some areas) will be brought in. Local authorities will be allowed to charge interest for these arrangements, meaning the scheme should be cost-neutral to the state. This will go some way to helping people access the care and support they need, but it cannot address the long-term funding challenges on its own.

We recommend:

- the universal system of deferred payment must be implemented alongside other proposals to enable the public to plan for their care
- the Government is clear that the costs of care will be recouped from people's estates at the appropriate time.

What does the minimum entitlement to social care mean?

In *Caring for our future: reforming care and support* and the draft Care and Support Bill, a minimum national eligibility threshold was introduced. This will make it compulsory for local authorities to provide social care for everyone whose level of care needs is above a certain level. However, the Government has yet to clarify what this threshold will be, and it is therefore impossible to know how much it will cost to implement and whether local authorities will have sufficient funding for this. Given the demographic pressures,

additional funding will almost certainly be necessary.

How would more integration between health and social care help?

A lack of joined-up care can result in patients needing more intensive, and thus expensive, support and can be distressing for them and their families. It is vital therefore that, in addition to investing in the long-term sustainability of social care, policies are implemented to overcome the barriers which currently prevent integrated care. People should have access to one comprehensive offer covering both health and social care, which they can understand how to navigate.

How do we ensure real and lasting integration of care?

Action is needed from the Government, national bodies, local authorities and NHS organisations to effectively overcome the barriers (as explained below) which currently prevent integrated care. This section outlines our main recommendations on this issue.

Overall, we would like to see a more coordinated approach nationally to policy development between health and social care. It is particularly important that new policies focus on enabling the NHS and local authorities to work together to use scarce resources effectively and coordinate care.

The NHS and local authorities each receive funding in different ways. Savings made through the actions of one service can accrue

Case study: Commissioning health and social care – a tale of two areas

Ed Macalister-Smith, chief executive of **NHS Bath and North East Somerset and Wiltshire PCT Cluster**, explains how his cluster works with two local authority areas. In one, there is a joint commissioning team between the local authority and the NHS. In the other, there is no equivalent team. He finds this makes it harder to jointly agree and implement commissioning plans and has, arguably, resulted in delays in commissioning decisions and lack of coherence of organisational objectives. Delayed transfers of care are low in the first area but are a significant cause of poor quality care and expense in the other.

Ed says: “It is difficult for government to require and mandate organisations to work together, as partnerships must be built on trust and strong relationships. Pressures are being felt within social care, due to rising demands and falling budgets. In the area where joint working is the norm, the pressures are not being felt so severely within the NHS. However, where joint working isn’t so well established, the pressures are being felt more acutely.

“The pressures on social care will continue and indeed worsen. We must find solutions together in order to ensure both systems deliver quality care for patients.”

to another with no easy route for sharing the savings between them. For example, if a local authority invests in someone to act as a care coordinator, this may well save a significant amount of money by reducing hospital admissions but the local authority would not automatically share any of this saving. This disincentive to collaborative behaviour is particularly significant given the extreme financial pressures.

We recommend:

- the current way in which many NHS organisations are paid for their activity (the national list of prices for episodes of care, known as the tariff system) is reformed to better support and incentivise integrated care. The present tariff system works best for short ‘episodes’ or care delivered by single organisations

- that Monitor develops model arrangements for risk pooling across health and social care and useable models for personal health budgets which incorporate patient care
- aligning funding streams to make integrated joint commissioning a reality, ensuring join-up between local authority funding allocations done per resident population and NHS allocations based upon GP practice populations. These two populations do not necessarily overlap.

Similarly, the inconsistency between fully funded NHS care, through NHS continuing healthcare¹ and means tested social care can both confuse users and hamper the delivery of a comprehensive care package

supporting care closer to home. Indeed, it may even act as a disincentive for people to find their own solutions to funding care on a long-term basis. Until this inconsistency is addressed there will be an inherent tension which will make the delivery of successful integrated health and social care difficult to achieve.

To address this inconsistency, we recommend:

- the Government outlines the long-term costs of ensuring a personal health budget for all those who qualify for NHS continuing healthcare
- the Government clarifies how NHS continuing healthcare packages will be commissioned in the new system, in order to facilitate risk pooling across larger geographical footprints.

Strong local relationships are crucial, and leadership in both the NHS and local authorities will be critical. A 2010 report, based on a survey of local partnership arrangements, highlighted that strong local relationships, trust

† NHS continuing healthcare is care and support provided to adults aged 18 or over which is arranged and funded solely by the NHS, and is, therefore free at point of delivery to the individual concerned.

References

- 1 Emerson C and Hatton C. *Estimating future need for adult social care services for people with learning disabilities in England*. Centre for Disability Research, Lancaster University.
- 2 2011 Census.
- 3 Alzheimer's Research UK.
- 4 Alzheimer's Society.
- 5 LGA (2012), *Funding outlook for councils from 2010/11 to 2019/20: preliminary modelling*.
- 6 *ibid.*
- 7 This figure is based on 2010/11 Department of Health reference costs and 2011/12 Department of Health acute delayed transfers of care.
- 8 <http://bit.ly/SYvft>
- 9 NHS Confederation member survey, July 2012.
- 10 HM Treasury Public Expenditure Statistical Analyses 2012 <http://bit.ly/S5pRDk> (Table 1.9)
- 11 Figures from House of Commons Library Deposited Paper 2012 – 0634, April 2012 <https://bit.ly/Ns10ZM>
- 12 Dept of Health (11 July 2012) 'Government publishes progress report on social care funding reform.'
- 13 NHS Confederation (2010), *Where next for health and social care integration?*

and a shared culture and vision were seen as very important in facilitating joint working and integration.¹³ The survey also showed that openness about shared financial pressures, resulting from positive, long-term relationships, enabled innovative decisions to be made. There is clear evidence that this openness can be pivotal in facilitating local service integration and, indeed, service redesign. As Ed Macalister-Smith

highlights above, this cannot be mandated by central government, but should be locally driven.

For more information on the issues covered in this *Briefing*, please contact kate.ravenscroft@nhsconfed.org or nicola.rosenberg@nhsconfed.org

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