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Social care funding and the NHS

An impending crisis?



Key points

- Adult social care has enjoyed an average annual real-terms growth of 5.1 per cent since 1994 but much of this has been absorbed by demographic pressures. Over the past five years spending on services for people with learning disabilities has risen by 20 per cent and for those with physical disabilities by nearly 14 per cent. But spending for older people has increased by less than 3 per cent and has not kept pace with demographic change.
- Many aspects of the NHS and social care interface have improved in recent years. Delayed transfers of care from acute hospitals have fallen from 3,600 a week in 2003/4 to 2,200 a week in 2008/9 and more people have received help to avoid being admitted to hospital. But there are wide variations in performance from one place to another that if tackled could offer substantial productivity gains.
- There is promising evidence that spending on the right kinds of social care can reduce inappropriate use of NHS resources, for example, through timely discharge from hospital, avoiding unnecessary admissions and reducing the length of stay. There is a growing awareness of the importance of preventive services but such investments often become a low priority when resources are squeezed.
- Mounting demands on care budgets has led the government to identify additional resources in the Spending Review and to commission an independent review to recommend a more sustainable way of funding care for the future. But a tough spending settlement for local government suggests that a funding gap of at least £1.2 billion could open up by 2014 unless all councils can achieve unprecedented efficiency savings.
- The consequences are that even fewer people will receive the care and support they need. This will have knock-on effects for people needing NHS care as there will be more emergency admissions to hospital, delayed discharges and longer waits for treatment.

- Social care is not simply an adjunct to the smooth running of the NHS. It is possible that under-investment in vital health services, such as continence and community nursing, may generate additional demand for social care support. A better understanding of the reciprocal relationship between spending in health and social care is essential to ensure that they operate as a whole system of care.
- Action to achieve better use of health and social resources could be taken in four areas by:
 - adopting a more unified national policy framework, for example, replacing existing separate processes with a single strategic assessment of the funding needs of the NHS and social care
 - developing a better understanding of local patterns of need, spending and outcomes, with metrics to support shared-investment decisions
 - closer alignment of resources through pooled and place-based budgets
 - a wider role for local government in promoting health and well-being, thus reducing the need for NHS and social care services.

Introduction

The government's proposals to reform the NHS have rekindled interest in improving the relationship between local government, social care and the NHS to allow resources to be planned that reflect people's needs rather than organisational boundaries. This follows on from the pledge in *The Coalition: Our programme for government* (HM Government 2010) to break down barriers between health and social care funding. It acquires a new urgency with the announcement in the 2010 Spending Review of an additional £1 billion for the NHS to invest in measures that support social care and benefit health. The government is also consulting on a new set of outcomes for NHS and social care that focus on the experience of people who use services.

There is general agreement that the closer integration of resources could secure long-term gains in efficiency, quality and productivity. *The Operating Framework for the NHS in England 2011/12* (Department of Health 2010) has confirmed the expectation that the NHS and local government should work together to achieve this. It is essential that there is a good understanding of the reciprocal relationship between health and social care spending. This paper examines recent trends in social care spending, summarises the evidence about the inter-dependency of these resources with those of the NHS, and identifies four areas for action to improve existing arrangements.

The government's plans to reform the NHS will see major changes in local leadership and new organisational arrangements that could destabilise existing agreements between councils and the NHS that have worked well in the past. Alongside fragile funding prospects for social care there is a risk that recent improvements will be reversed and that access to the right services, in the right place, at the right time, will deteriorate.

Where we are now

Spending has grown

Spending on adult social care has experienced more than 15 years of real-terms growth and has nearly doubled since 1994 (see Figure 1 opposite).

Although this equates to an average annual increase of 5.1 per cent, the actual growth has been very uneven – ranging from 10.6 per cent to a small reduction of 0.3 per cent in 2007/8 and a much lower real growth over the four years from 2005/6 (see Figure 2 opposite).

Figure 1 Net expenditure on adult social care 1994–2009

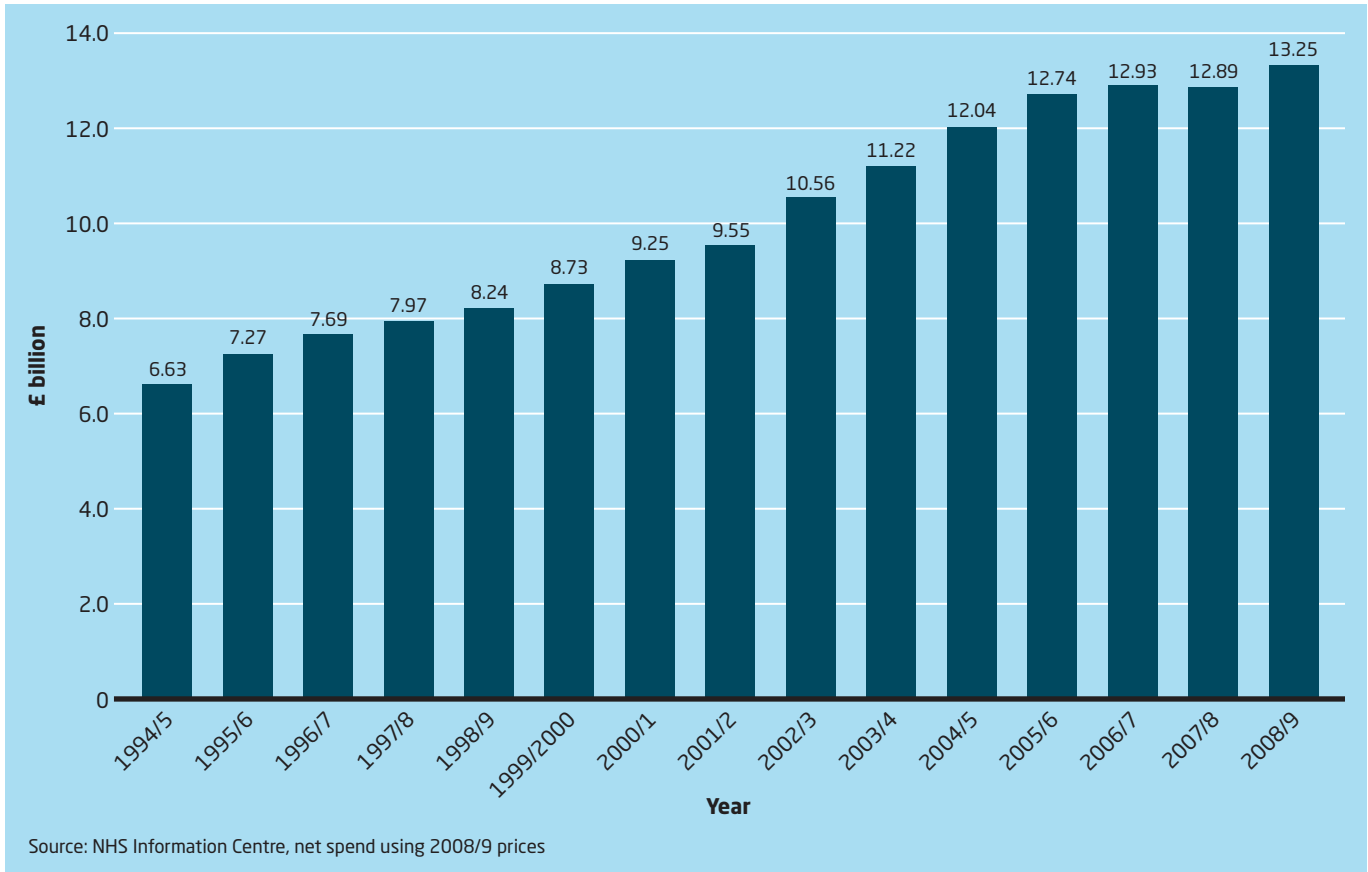
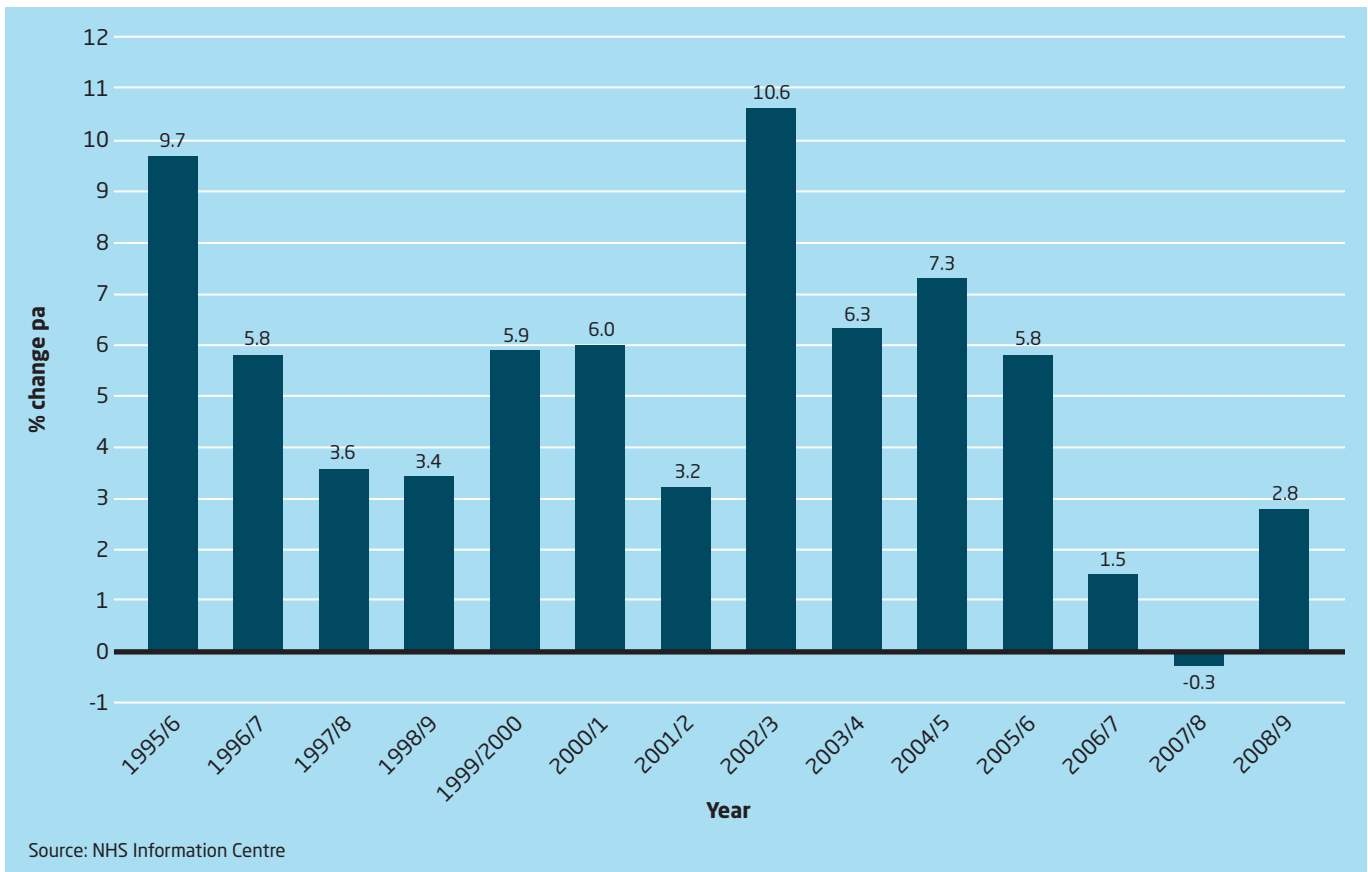


Figure 2 Change in net expenditure on adult social care 1995–2009



The NHS has enjoyed even higher levels of growth, with an increase of 130 per cent in real terms over the same period and an average annual increase of 6.1 per cent.

Although services have benefited from extra spending, it has not been applied in a coherent or consistent way (*see* box below). This represents a missed long-term opportunity over a period of sustained economic growth.

Local and national funding: a policy fault-line?

Local social care services are funded in an entirely different and much more localised way than the NHS. This reflects the continuing legacy of the settlement after the second world war in which the NHS was established as a centrally directed service, largely free at the point of use, while personal social services were the responsibility of local councils and subject to means-testing. The bulk of social care resources come from central government funds allocated via the Department of Communities and Local Government (DCLG) based on a 'formula spending share' calculation. There is no specific allocation for social care other than a small number of specific grants allocated by the Department of Health. In the light of this allocation, councils then set their budget and agree the level of council tax – which represents 39 per cent of total expenditure – but in some councils as much as 80 per cent of spending is funded this way. Total national spending on social care is therefore the aggregated product of separate decisions made by 152 councils. This locally determined pattern of spending then shapes Department of Health planning in terms of Spending Review bids and the eventual settlement. These dislocated funding processes make it difficult to align NHS and social care resources with national policy objectives in a coherent and co-ordinated way.

Spending and services have changed

Although there has been a substantial real-terms increase in spending, there are marked differences in the extent to which different groups of people have benefited (*see* Figure 3 opposite). Despite an ageing population, gross spending on social care for older people over the past five years rose by less than 3 per cent. It has barely increased in the past three years and in 2007/8 actually fell. In contrast, over the same period, spending on services for adults with learning disabilities grew by 20 per cent and for those with physical disabilities by nearly 14 per cent. This reflects the increasing longevity of working-age adults with disabilities and the higher costs of the care and support they require. This places an escalating pressure on council social care budgets (Local Government Association and Association of Directors of Adult Social Services 2010).

Over the same five-year period the number of older people using publicly funded social care services has fallen by almost 7 per cent, whereas the number of 18–64 year olds using services has increased by nearly 12 per cent. There has been a drop of more than 30 per cent in the number of people aged 65 years and over receiving residential care and a decrease of more than 18 per cent in those receiving nursing care (*see* Figure 4 opposite). This is in line with the policy of promoting independence, but there has not been a compensating expansion in community-based services such as home care, day care and adaptations. The number using these services has fallen by 5 per cent.

These trends are consistent with a general picture of councils restricting help to smaller numbers of older people with more intensive needs, with help no longer available to those with moderate or lower levels of need. In nearly three-quarters of councils, services are available only to those with critical or substantial needs, at the expense of lower-level

Figure 3 Gross expenditure on each user group 2004–9 (2008 prices)

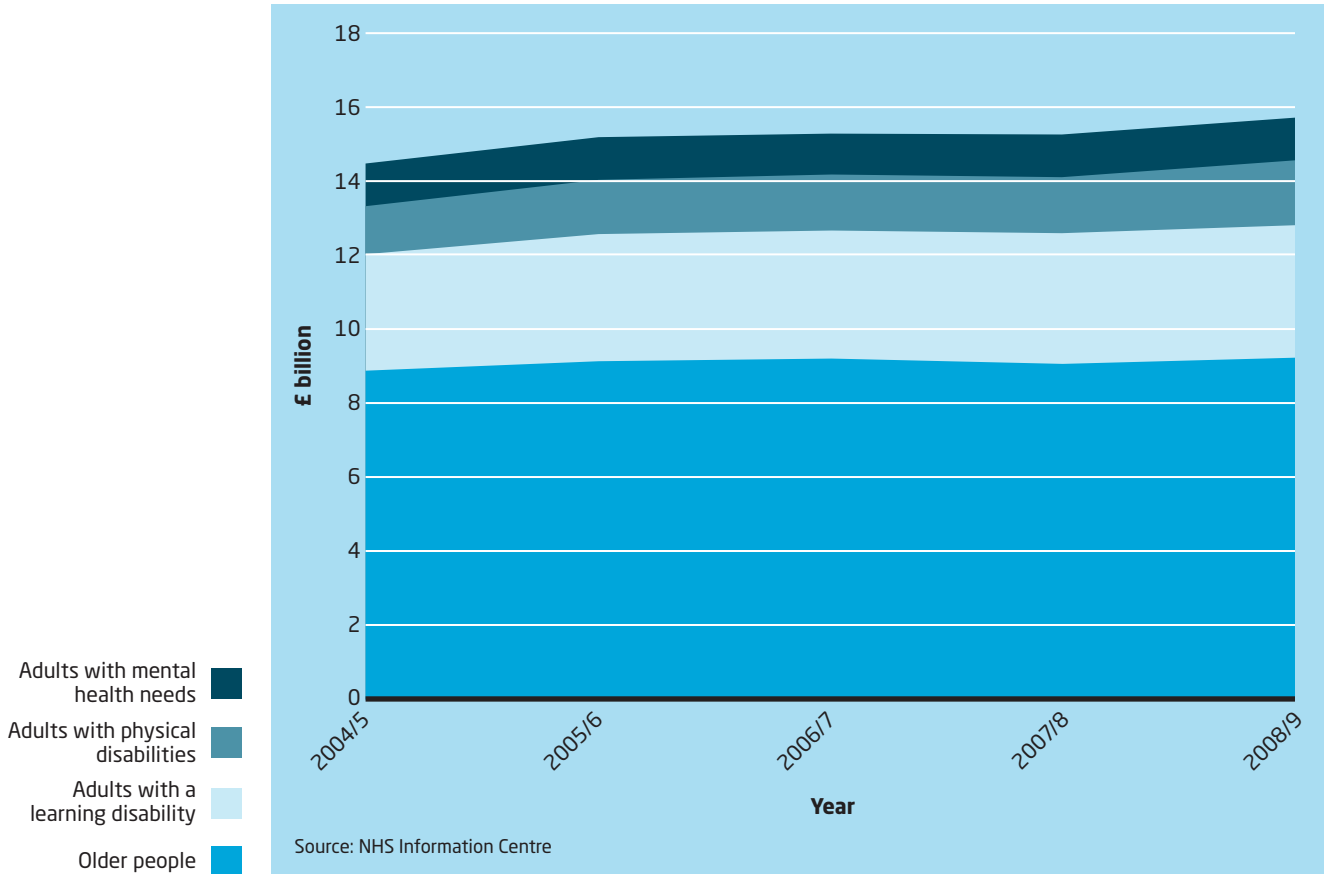
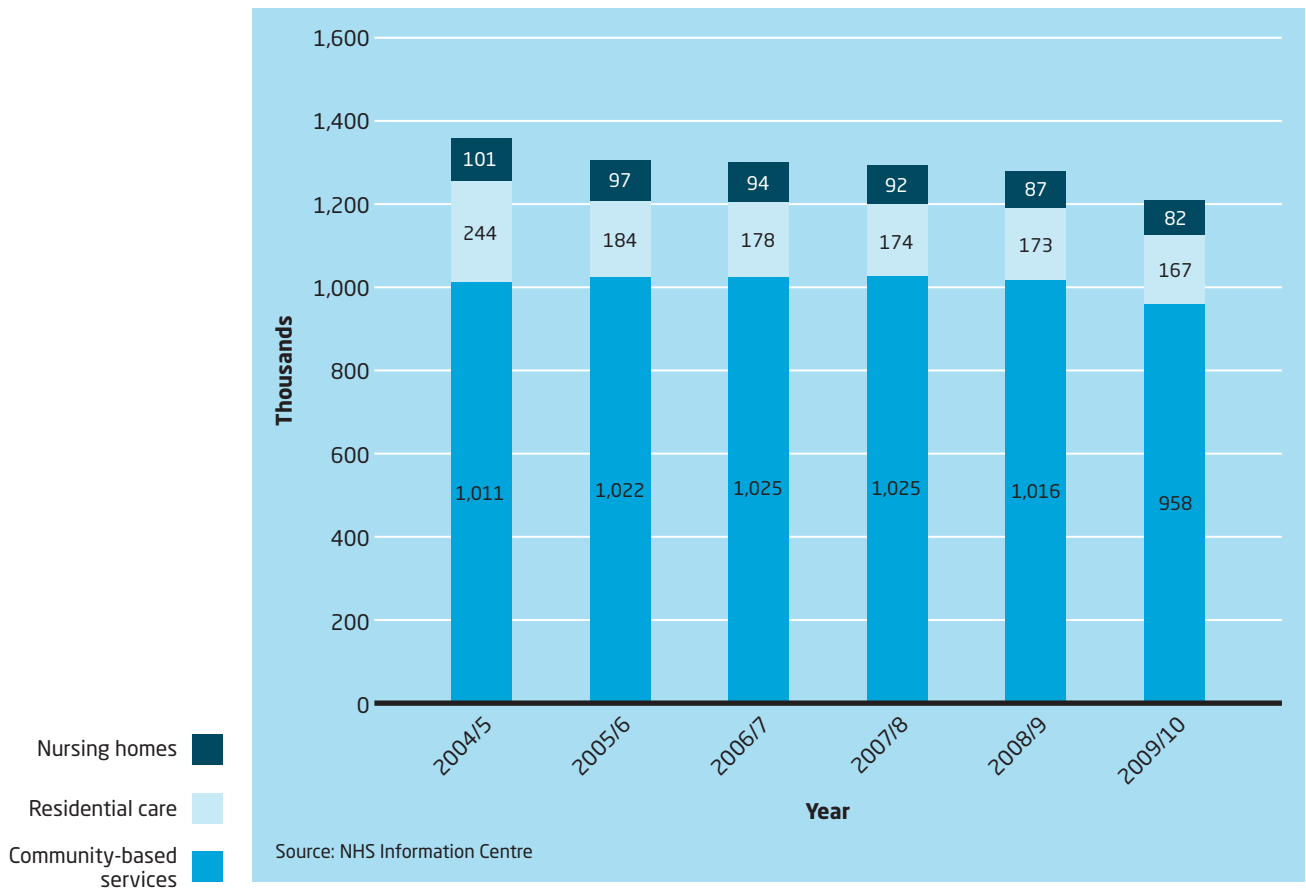


Figure 4 Numbers of people aged 65+ years using publicly funded services



support, early intervention and preventive services that may delay the need for more intensive help.

Whereas councils are clearly trying to respond to rising numbers of working-age people with social care needs, for older people the trend towards a decline in spending with fewer people receiving services defies demography. Over this same 5-year period the older population in England increased by almost 6 per cent and the population of those over 85 years by nearly 25 per cent. It is possible that many councils are achieving more with less, for example, more than £940 million in cash-releasing efficiency savings has been found in the past three years (Association of Directors of Adult Social Services 2010). But even allowing for this, the overall trend has worrying implications for the NHS given that older people are relatively intense users of acute hospital care, with around two-thirds of all beds occupied by older people.

Productivity

How well have these extra resources, invested in health and social care over the past decade, been translated into more services for people? Our recent assessment of NHS performance concluded that productivity overall has declined over the past decade, despite the introduction of stronger incentives through new hospital payment systems and quasi-market reforms aimed at reducing production costs. Since 2002, higher pay costs have absorbed more than half of the increase in financial resources for the NHS (Thorlby and Maybin 2010).

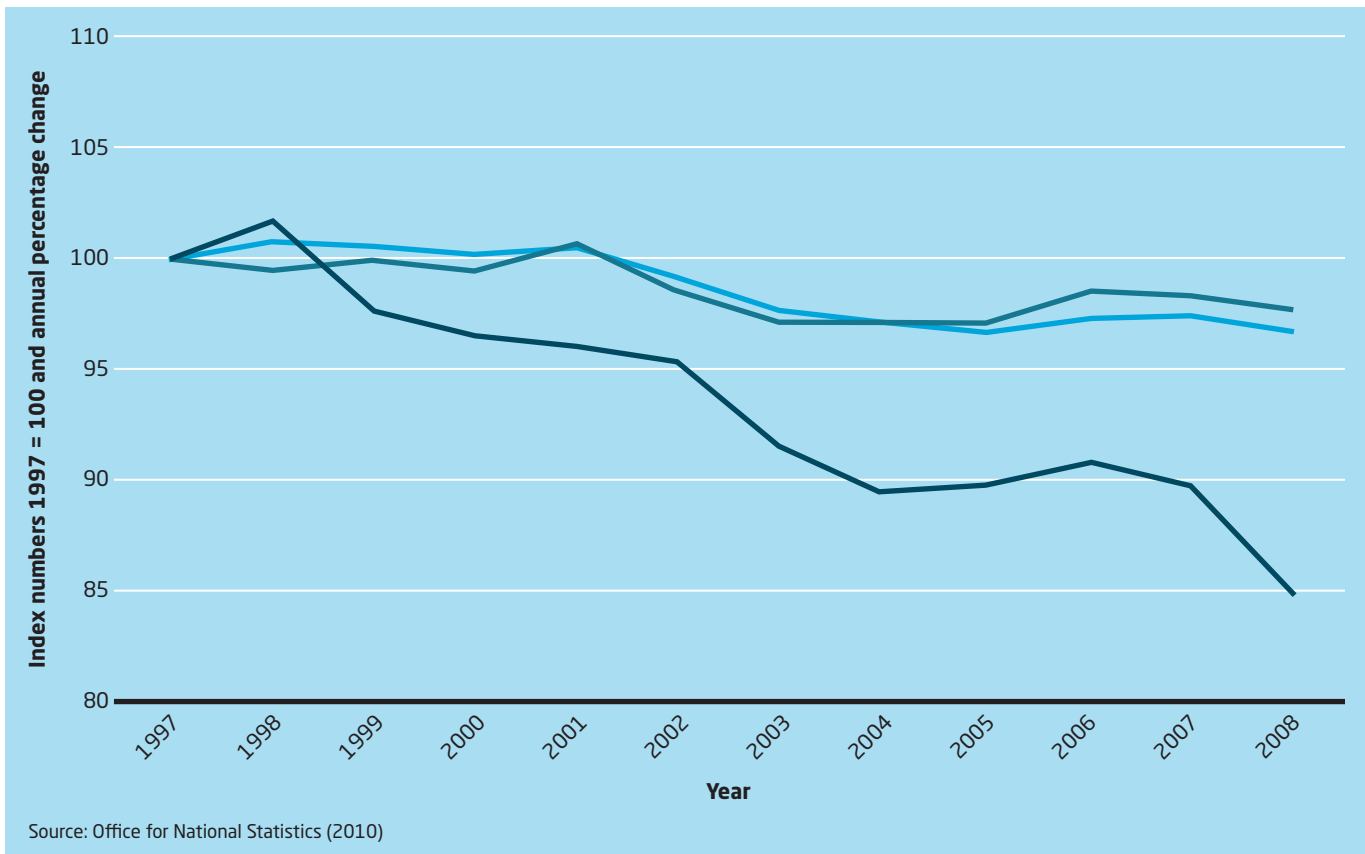
For adult social care the fall in productivity is striking – 15.3 per cent over the decade – an average annual fall of 1.5 per cent compared to a fall of 2.2 per cent (0.2 per cent per year) for health care and 3.3 per cent (0.3 per cent per year) for all public services (Office for National Statistics 2010). Unlike health, the social care estimates do not take account of quality changes, with evidence from regulators that the performance and quality of services have improved significantly in recent years (for example, Commission for Social Care Inspection 2009). The apparent decline in productivity may also reflect increases in the intensity of care provided for clients not reflected in the current output measure. The use of cost weighting for care provided at home may reflect its lower cost but not the value that many users put on remaining in their own home for as long as possible. But even allowing for methodological issues and underlying quality improvements, the scale of the difference in productivity between adult social care and other services, including the NHS, is stark (*see* Figure 5 opposite).

Future prospects

The 2010 Spending Review provides a real-terms increase in grant funding for social care of around £875 million a year on average over the next four years. This will be provided through the Department of Health's Personal Social Services grant, which will be merged into the local government formula grant. A further £1 billion a year by 2014/15 will be set aside from the NHS budget for partnership working between the NHS and social care (£800 million in 2011/12). As the Chief Executive of the NHS states 'this upstream expenditure in meeting the needs of vulnerable people will represent a better quality and more efficient service across the health and social care system, preventing the need for greater expenditure downstream in acute health care' (Nicholson 2010). This will include funding for re-ablement services that support people when they return home from hospital, increasing from £150 million in 2011/12 to £300 million a year from 2012/13.

This settlement is a welcome recognition of the pressures on the social care system, but it is not ring-fenced and there is no guarantee that it will be spent on social care. With

Figure 5 Health and social care productivity 1997–2008



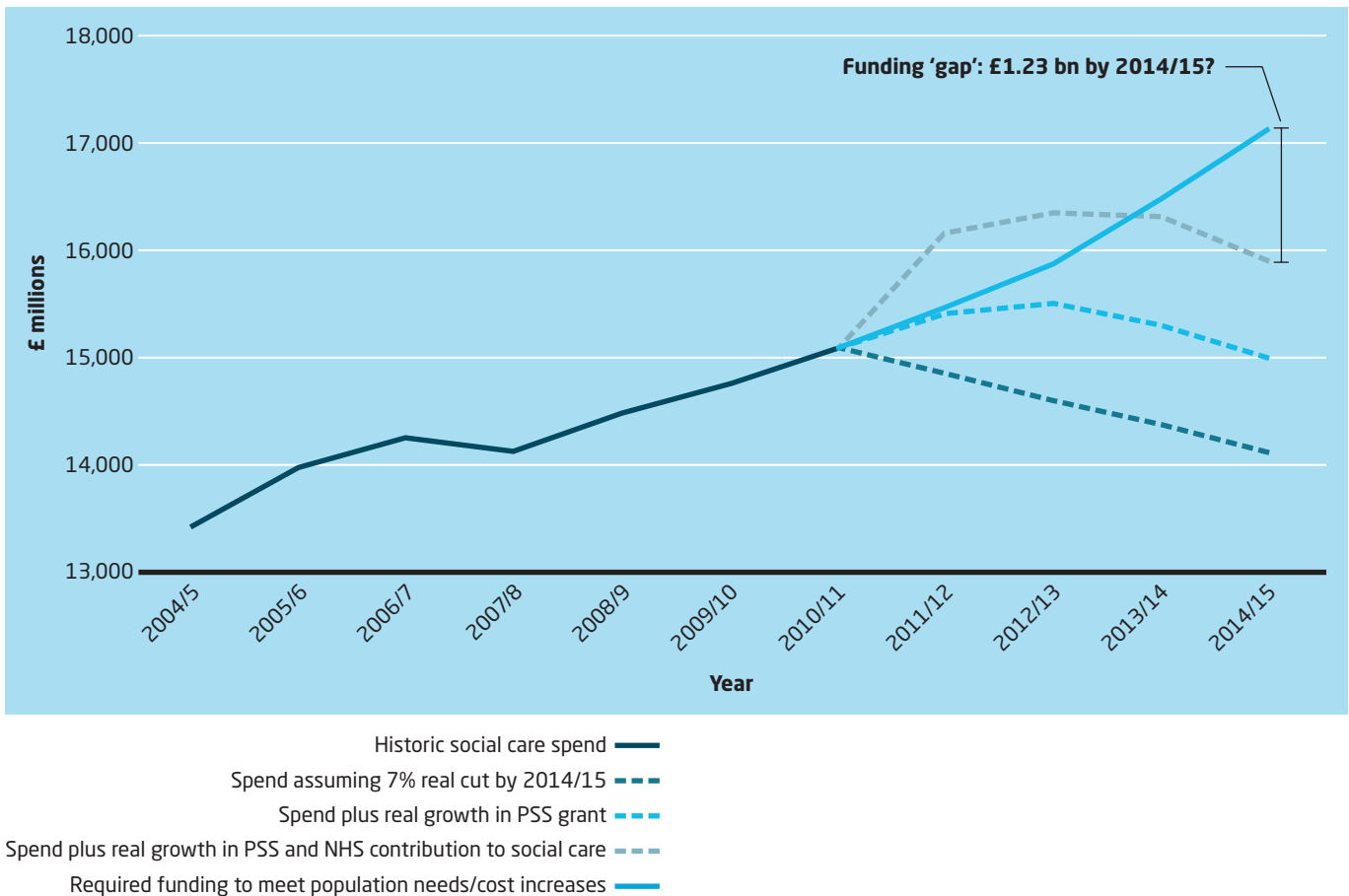
Adult social care —
 NHS —
 All public services —

adult social care the largest area of expenditure in many local authorities and local government facing a 27 per cent reduction in its overall grant, social care services will be vulnerable to competing local priorities. How far councils can cushion social care budgets will vary widely. It will depend on local factors such as the availability of financial reserves, the potential for further gains in productivity and efficiency, and whether there is any room for manoeuvre in the setting of council tax levels, which is unlikely in view of the coalition government's pledge to freeze council tax. Some councils are likely to consider increasing individual user charges, especially for non-residential services, and the relatively few councils still providing care for people with 'moderate' needs may consider tightening their eligibility criteria. They will face difficult choices to protect social care funding. Even relatively modest reductions in social care spending by councils would lead to a sharp rise in older people going without support to remain at home and would place extra demands on informal carers (Forder and Fernández 2010).

Figure 6 overleaf provides an illustration of the possible gap between future social care spending following the DCLG local authority settlement plus other changes announced in the 2010 Spending Review. They are based on three scenarios arising from the 27 per cent real reduction in the central government grant to local authorities (HM Treasury 2010) that between 2011/12 and 2014/15 social care spending: will be fully protected by all councils (a real-terms cut of 0 per cent); will receive some protection (a real-terms cut of 7 per cent); or will receive no protection (a real cut of 14 per cent).

The aggregate average national picture suggests that the outcome of the Spending Review, coupled with a public sector pay freeze, should ensure sufficient funds are available to

Figure 6 Future social care spending: the funding gap (2010/11 prices)



more than cover assumed funding needs in 2011/12 and 2012/13. (see Appendix on p 20 for further information). However, under an 7 seven per cent real cut in social care spending over the Spending Review period, in 2013/14 a gap starts to open, reaching an estimated £1.23 billion in 2014/15.

Clearly, the scale of the potential funding gap at local level and hence options for addressing this will depend on local circumstances, history and priorities. One option is to use resources more productively. Efficiency savings of around 2 per cent each year for the period of the Spending Review would be enough to close the estimated funding gap under the 7 per cent scenario. If the baseline scenario is closer to a real cut of 14 per cent, however, then efficiency gains of around 3.5 per cent per year would be required. This is more than the 2–3 per cent savings per year that councils have realised over the past three years.

There will be particular concerns that reductions in care home placements and support for people at home may increase the number of avoidable hospital admissions and delayed transfers of care, working against the efforts of NHS to reduce the use of expensive acute care. Reduced social care budgets will make it much harder for councils and providers to work with the local NHS to meet its own productivity challenge and will undermine the rationale for ring-fencing NHS budgets. The full implications of the settlement for social care spending will not become clear until councils set their budgets.

This is in the context of a Spending Review settlement for the NHS involving an average 0.1 per cent real-terms increase over the next four years and a requirement to find up to £5 billion productivity improvements a year through to 2014/15 to meet increased demands and improve the quality of its services. This is the biggest financial challenge

that the NHS has faced in its history. Thus the financial fortunes of both the NHS and adult social care are intertwined and much will depend on the particular circumstances of each council as to whether reductions in services can be avoided.

The inter-dependency of social care and NHS resources

General awareness of the importance of social care provision in supporting the NHS to treat patients and of the overlapping nature of health and care needs has been a driving force behind health and social care collaboration since the inception of the NHS. In one local study, 90 per cent of people who received social care also received secondary health care over a three-year period (Care Quality Commission 2010). Growing numbers of people with long-term health conditions often have a mixture of needs that require an integrated response so that they can live as independently as possible without recourse to inappropriate admissions to hospital or long-term care.

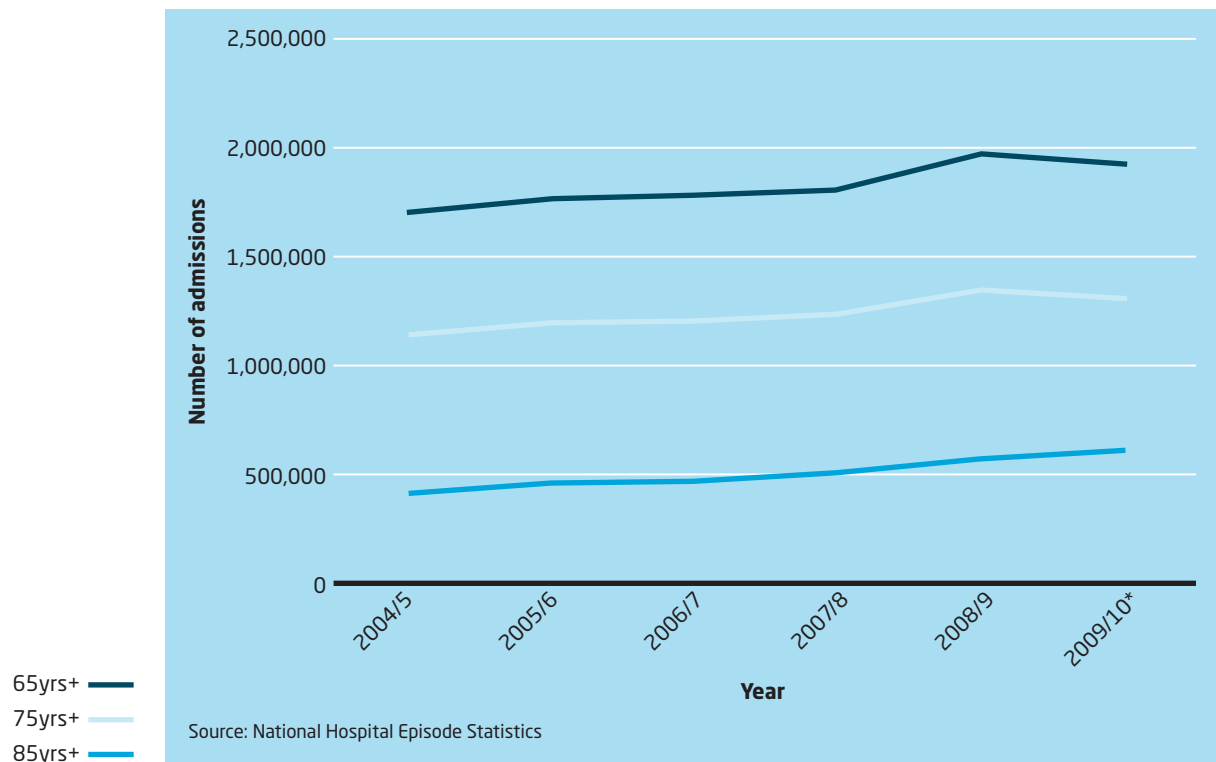
Adult social care could improve the effectiveness of the NHS in the following ways.

- Investment in services that reduce the need for NHS care, especially in hospital, and its duration. Examples of this might be intermediate care that enables people to be discharged from hospital in a safe and timely fashion, thus reducing the likelihood of re-admission, and prevention and early intervention services that reduce the need for health care by enabling people to stay well and live independently in their own homes.
- Collaborative processes that enable professionals from different disciplines and agencies to achieve better outcomes for patients, for example, through single or shared assessment frameworks, integrated locality teams and integrated care pathways.
- Organisational arrangements that commit councils and their local NHS partners to work together, for example, through pooled budgets, integrated commissioning, joint appointments and shared back-office functions. The ultimate expression of this would be complete organisational integration through the establishment of a care trust.

In practice none of these examples is mutually exclusive and a variety of different approaches are used concurrently. This makes it difficult to evaluate their differential impact. The role of culture and leadership at a local level is a key element. An important theme in many evaluations of partnerships and integration initiatives has been the personal chemistry between key local players, the quality of relationships between people and organisations, and the time needed to build up mutual trust (NHS Confederation 2010). The King's Fund will be publishing a discussion paper on the integration of health and social care, which will address collaborative and other organisational arrangements (Humphries 2011, forthcoming).

Here we concentrate on the use of resources across the social care and NHS interface, where there have been demonstrable improvements in some aspects of the co-ordination of services. Delayed transfers of care from acute hospitals have fallen from 3,600 a week in 2003/4 to 2,200 a week in 2008/9. A total of 148,000 people had access to services that helped them to avoid being admitted to hospital as an emergency, compared to 80,000 in 2004. A further 157,000 had access to services that helped them to return home quickly from hospital, compared to 112,000 five years ago (Care Quality Commission 2010).

Access to publicly funded social care has become more difficult in many places over the past decade, with most councils restricting help to those with substantial and critical needs. This contrasts with substantial improvements in access to NHS care. There have been some major shifts in the boundaries of NHS and social care in recent years, for example, the run-down of long-stay NHS wards has seen older people receiving long-term care in residential care or nursing homes instead, with a gradual shift of

Figure 7 Emergency hospital admissions for older people, 2004/5 to 2009/10

* Provisional data

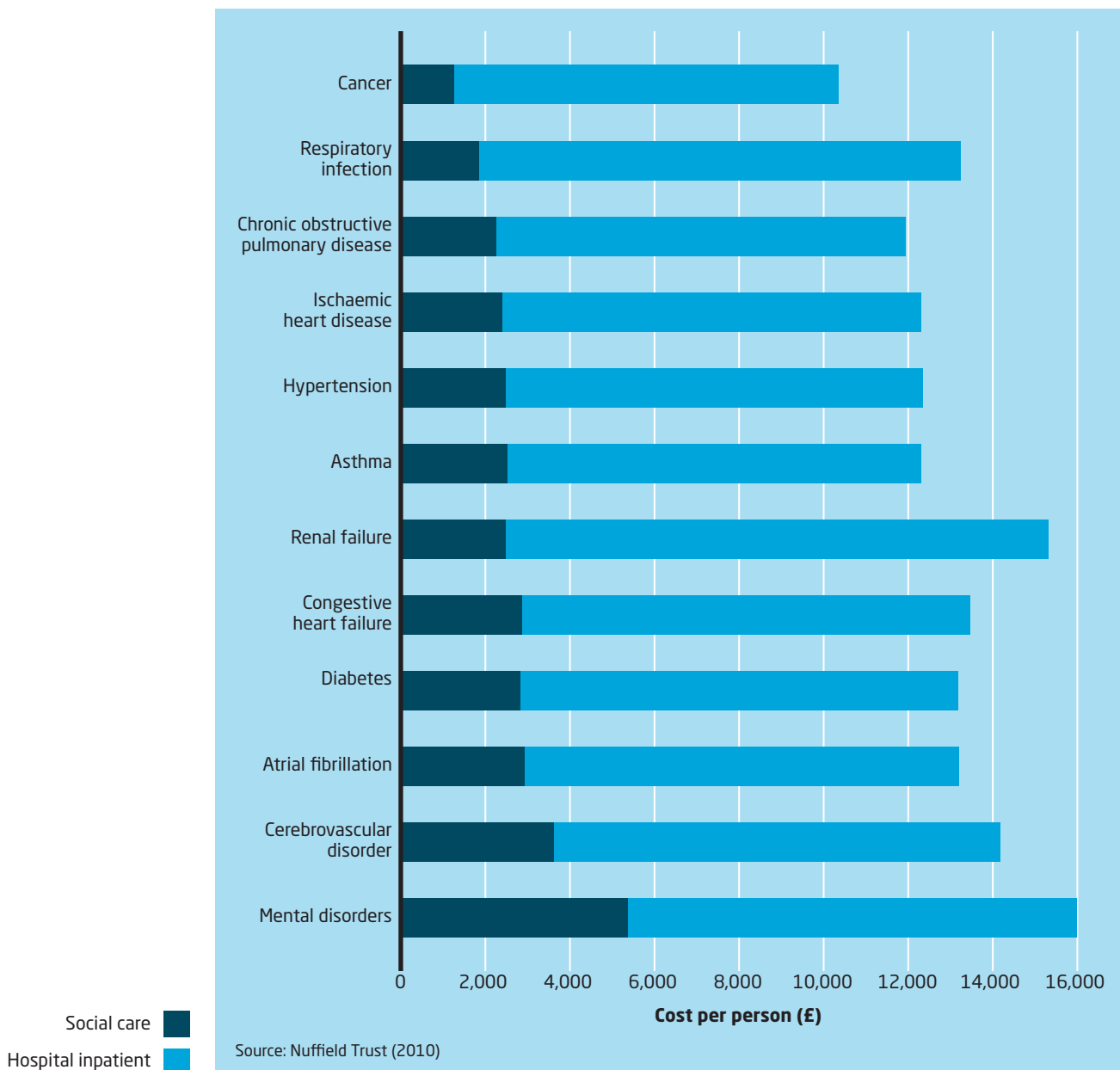
funding responsibilities towards councils, individuals and families. Community care and independent living for people with learning disabilities have contributed also to the blurred boundaries between the NHS' and councils' social care responsibilities.

Emergency hospital admissions are usually cited as an example of the pressures created for the NHS by inadequate social care support in the community. Certainly these have risen for older people by more than 12 per cent since 2005 (*see* Figure 7 above) – just above the increase for the whole population of nearly 10 per cent. That emergency admissions have been rising in recent years for all age groups – including those less likely to have social care needs – suggests that changes in social care resources are not a significant factor (Blunt *et al* 2010). But emergency admissions have increased by 48 per cent for people aged over 85 years and attention should be concentrated on this age group.

A recent study based on more than 16,000 people in three primary care trust (PCT)/council areas also found that the balance of hospital inpatient and social care costs shifted dramatically with increasing age. Higher social care costs at the end of life tend to be associated with lower inpatient costs, leading the authors to suggest that any reductions in council-funded social care might increase demand for hospital services (Nuffield Trust 2010).

Another pressure point in the NHS and social care interface is in the spending on continuing health care, where the boundaries between NHS and local council responsibilities can be very fluid. The numbers of people receiving NHS-funded continuing care have risen dramatically since 2007 by 80 per cent from 24,952 to 44,294 in 2008/9 (Hansard 2010–11). Much of this increase can be attributed to the effects of new guidance clarifying NHS responsibilities in 2007 and 2009, as the Department of Health has acknowledged (Department of Health 2009b). The introduction of a national framework has clarified how eligibility for NHS-funded care should be determined. It has also promoted greater consistency of assessment and decision-making and raised

Figure 8 Average costs of social care and hospital treatment per person in the last 12 months of life, by diagnostic group



general awareness among professionals, patients and the public of the rights of appeal against PCT decisions.

The Nuffield study also found that the use of social care by people with long-term conditions varied widely by diagnosis: people with mental health problems, falls and injury, stroke symptoms, diabetes and asthma tended to use more services. People with cancer appeared to use local authority-funded social care the least (*see* Figure 8 above.)

A clearer understanding of these inter-relationships between health and social care is hampered by wide geographical variations in cost and performance across a range of measures such as numbers receiving intensive home care, emergency hospital admissions, use of residential care and delayed transfers. There are substantial differences that cannot be explained by differences in need (Care Quality Commission 2010). For example, there is more than a thirty-fold variation in the proportion of people whose discharge from hospital is delayed, leading to the avoidable use of expensive hospital-based care.

Some older people are admitted to hospital as emergencies two or more times a year, and some of these admissions might not be necessary if people were cared for better in the community. The Care Quality Commission has estimated that if best performance on reducing these admissions of people aged 75 years and over could be achieved everywhere, hospitals could make an annual saving of around £2 billion (Care Quality Commission 2010). Similar variations in the patterns of spending and activity by councils indicate the potential for substantial gains in productivity and efficiency (Department of Health 2009b).

The impact of services

The overlapping and sometimes complex needs of people who use health and care services require a co-ordinated response from a range of different agencies to ensure that they receive the right care, in the right place, at the right time, through clear signposting, assessment and agreed pathways that guide people's journeys through the system. This demands a balanced spectrum of services across primary, community and acute health care, social care and wider services that promote well-being, including local government and the independent and third sectors. It is in the context of an integrated whole systems and person-centred approach that the relationships between specific social care and health services should be viewed.

Intermediate care and re-ablement

Councils contribute significantly towards the cost of jointly funded and commissioned intermediate care services, including re-ablement services. These can help to avoid inappropriate hospital admission, achieve optimal length of stay and reduce delayed transfers of care. The number of people receiving council-funded non-residential intermediate care has risen by more than 40 per cent in the past four years. The number of people receiving the corresponding residential care has increased by more than 20 per cent. That this expansion does not appear to have arrested the continuing growth of emergency admissions of older people suggests that facilitating timely discharge rather than admission avoidance has been the principal benefit.

National evaluations of intermediate care have produced mixed results due to the diversity of different service models and arrangements. Nevertheless there are numerous local examples of intermediate care services that have helped to reduce the use of hospitals and intensive social care (see case study in box opposite). It has been suggested that this kind of integrated response service to people who have a crisis within a four-hour period could save an average of £2 million per PCT and £0.5 million per local authority by reducing ambulance call-outs, unnecessary admissions to hospital and unplanned entry to long-term nursing or residential care (Department of Health Evidence to Health Select Committee 2010–11).

A number of councils are beginning to report evidence of the positive effects of re-ablement services – usually funded exclusively by councils – in reducing the need for ongoing social care support. One study suggested that 53 per cent to 68 per cent of people left re-ablement requiring no immediate homecare package, and 36 per cent to 48 per cent of those continued to require no homecare package two years after re-ablement (Care Services Efficiency Delivery 2007).

The impact on the use of health services is less clear. The Care Quality Commission claims that nationally 78 per cent of people who use rehabilitation and re-ablement services achieve independence when they leave hospital (Care Quality Commission 2010). However, these services usually incorporate other interventions such as telecare, aids

Case study: Examples of effective use of resources in adult social care

The **Norfolk** Night Owls crisis response service has prevented an estimated 981 ambulance callouts, 442 A&E attendances and 95 hospital admissions and saved £302,000.

The **Milton Keynes** Rapid Assessment and Intervention Team, jointly funded by the Council and PCT, has shown that, over a 12-month period, 722 hospital admissions and 100 admissions to residential or nursing home care were avoided. Total savings to health and social care were £3 million (the largest proportion went to health care but with a minimum of £400,000 to social care).

The Rapid Response Service in **Salford** offers intermediate care through a pooled budget. In 2007/8 at least £1 million was saved (£689,000 to health and £378,000 to social care) as a result of diversion from hospital and residential placements.

Croydon Council and PCT have used a range of initiatives resulting in reduced emergency admissions to hospital and to care homes, including a 'virtual ward' in the community using predictive tools to focus primary care on those most at risk of hospital admission.

(Examples cited in *Use of Resources in Adult Social Care: A guide for local authorities*, Department of Health 2009b)

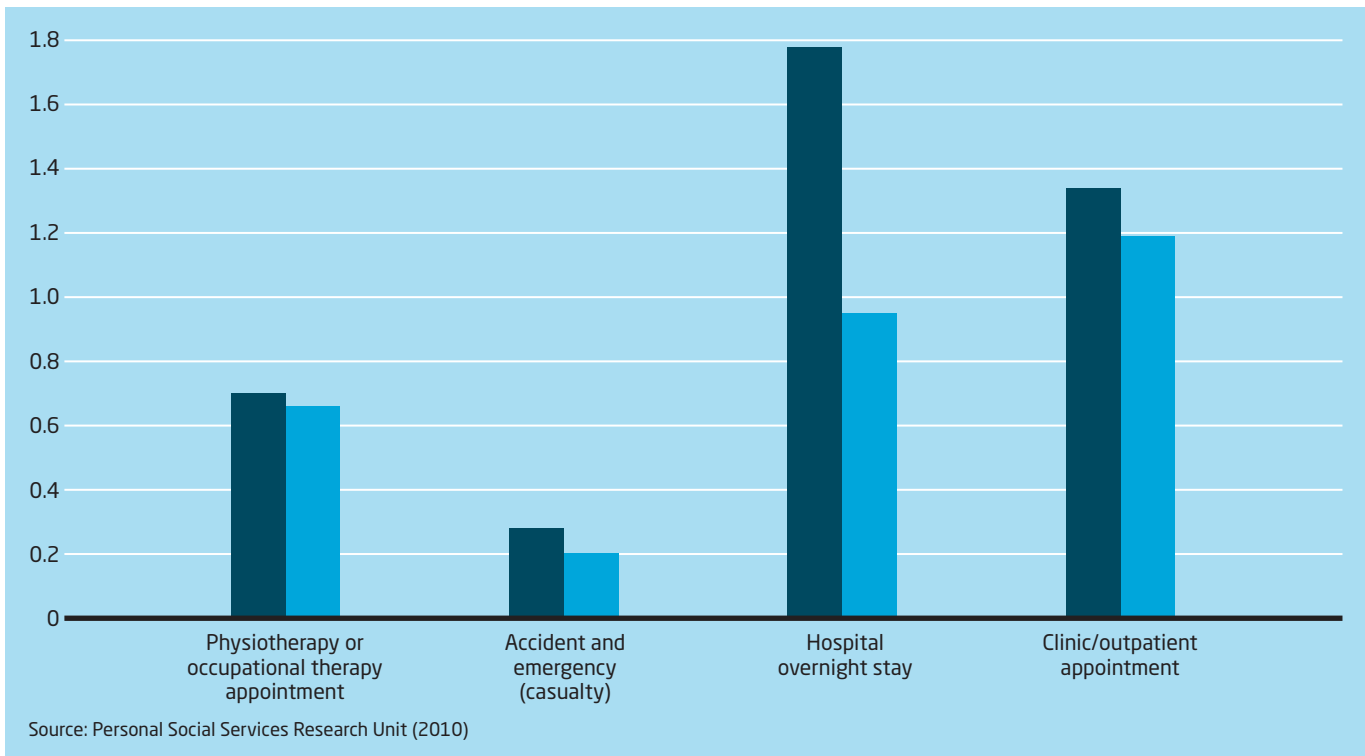
and community equipment, often with a health component such as physiotherapy or occupational therapy input. These factors, along with a variety of different service models and funding arrangements, make it difficult, if not impossible, to isolate and measure the impact that is specific to the social care contribution.

It is not clear whether increasing investment in these and other services beyond a certain point will necessarily produce further benefits to the NHS. Councils that respond to delayed hospital transfers by making additional care home placements may be making their situation worse by diverting resources away from services to support people at home (Department of Health 2009b). It is important to find the optimal balance of resources across the system but this will vary from place to place.

Prevention

Evidence about what works in prevention is much more fragmented and under-developed than more established areas of policy, and methodological challenges have made it difficult to develop a firm evidence base (Allen and Glasby 2010).

The most encouraging recent evidence comes from the evaluation of the Partnership for Older People Projects (POPP), a range of initiatives aimed at promoting health, well-being and independence and preventing or delaying the need for higher intensity or institutional care (Personal Social Services Research Unit 2010). More than a quarter of a million people (264,637) used one or more of these services in 29 pilot sites. PCTs were involved, alongside council and voluntary sector partners, with the ongoing funding of POPP projects within all pilot sites and provided at least half of the necessary ongoing funding for 35 per cent (n=51) of projects. Many of the projects were 'hospital-facing', for example, the rapid response team and hospital in-reach falls prevention service in East Sussex, the proactive case-finding project in Poole, and Southwark's community and hospital discharge pathways.

Figure 9 Self-reported use of secondary care services (mean numbers)

Time 1
(pre-intervention) ■

Time 2
(post-intervention) ■

The evaluation of these schemes found a significant and negative relationship between spending on POPP projects and the costs of emergency hospital bed-days for people over 65 ($p < 0.01$), and that every additional investment of £1 in them produced £1.20 additional benefit in savings on emergency bed days. These financial benefits were seen throughout the local system along with improvements in older people's quality of life. Based on self-reporting by participants, hospital overnight stays reduced by almost half (47 per cent) and use of A&E departments by almost a third (29 per cent) (see Figure 9 above). Reductions were seen in physiotherapy/occupational therapy and clinic or outpatient appointments by almost one in ten. In one project, a proactive case co-ordination service, where visits to A&E departments fell by 60 per cent, hospital overnight stays were reduced by 48 per cent, phone calls to GPs fell by 28 per cent, visits to practice nurses reduced by 25 per cent and GP appointments reduced by 10 per cent.

Such change had an impact on costs, with a total reduction of £123 per person over the median administration period of six months (see Table 1).

Table 1 Mean cost of change of secondary care service use

Service use	Pre-intervention (t1) mean cost	Post-intervention (t2) mean cost	Mean cost change
Physiotherapy	£14.23	£9.67	-£4.56
A&E	£80.59	£79.43	-£1.16
Hospital overnight	£188.46	£115.87	-£72.59
Outpatient	£182.48	£137.71	-£44.77
Totals	£465.76	£342.68	-£123.08

Source: Personal Social Services Research Unit 2010

However, pooling of data across the whole programme, and shared-funding arrangements, made it difficult to pinpoint the impact of particular projects and identify the contribution of local authority social care funding.

This evidence of the POPP projects leading to cost-reductions in secondary, primary and social care was similarly demonstrated by many of the local evaluations. The main difficulty for sites was translating the evidenced cost reduction into a cost saving. 'Moving monies around the health and social care system was seemingly a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation' (Personal Social Services Research Unit 2010). There is a real challenge where collaboration across organisational boundaries may see the costs fall to one part of the system, whereas the benefits are realised in another. This presents a compelling argument for pooled budgets.

A systematic review and critical appraisal of a range of early intervention programmes – the Supporting People, POPP and LinkAge Plus programmes – suggested that these integrated approaches could generate resource savings of between £1.20 and £2.65 for every £1 spent (Turning Point 2010). Many of these initiatives could offer valuable lessons to guide NHS commissioners and councils in considering how best to use the £1 billion allocated within the NHS settlement to support social care.

NHS spending on social care

Much of the discussion of these issues is based on the assumption that the role of social care is as a supportive handmaiden to the NHS. The impact of NHS activity and spending on social care should also be considered, remembering that achieving the best outcomes for the individual is the paramount aim of the system as a whole. Ill-health and co-morbidity is a major contributory factor in admissions to permanent residential care, especially incontinence, dementia and depression (Institute of Public Care 2010). Some evidence is beginning to emerge that investment in these services and in better dental care, podiatry services, incontinence, dehydration monitoring, falls prevention and stroke recovery may reduce demand for both social care and secondary health care (Care Services Efficiency Delivery 2008). This has led the Department of Health to argue that 'local PCT investment in good primary care for older people can reduce both the emergency admissions to hospital and the consequent demands for social care from older people' (Department of Health 2009b).

The *Operating Framework for the NHS in England 2011/12* (Department of Health 2010) acknowledges that reduced length of stay in hospital beds can put pressure on social care places. However, the National Audit Office has pointed out that over the past three years PCTs have been spending an increasing proportion of their allocation on general and acute secondary care and a decreasing proportion on primary care. The proportion of the allocation spent on community health services has risen very slightly but has decreased on services for those with mental illness and learning difficulties (National Audit Office 2010).

This is an area where we need a much better understanding of the reciprocal impact of NHS and social care investment and activity.

What can be done?

A unified view of funding

Recent trends in council spending on social care for older people do not inspire confidence that services are sufficiently funded to meet future demographic growth or to support the NHS in responding to the same challenge. People needing adult social care have not enjoyed the substantial improvements to access seen in the NHS and differential access causes problems for both services. This underlines the importance of the work of the Dilnot Commission and the urgency of achieving a new funding settlement for social care (Humphries *et al* 2010).

This is not simply a matter of injecting additional resources into an unchanged system but achieving the right configuration of NHS and social care resources, as the Health Select Committee has warned recently (Health Select Committee 2010). The different national arrangements for allocating resources to the two services produce competing pressures between national priorities in the NHS and a localist approach to local government. Total public resources for adult social care are determined by history and incremental change rather than current and future needs.

The national fault-line between NHS and social care funding hinders rather than helps the local alignment of these resources around people's needs. Although the additional £1 billion identified from NHS budgets to support social care is a welcome stimulus, there is, in the words of the Health Select Committee '... a risk that the sum will be focused on funding certain limited services, rather than being directed towards providing a better overall interface between the two sectors which will bring about longer-term improvements in efficiency, preventive care and re-ablement' (Health Select Committee 2010). The focus for alignment should be on the entire £121 billion allocation across the health and support system, possibly moving towards a single, shared settlement for both services. There is a case for carrying out a three- to five-year assessment of the long-term resource needs of the NHS and the care and support system as a single exercise, rather than as separate activities within the Spending Review framework.

A better understanding of local needs

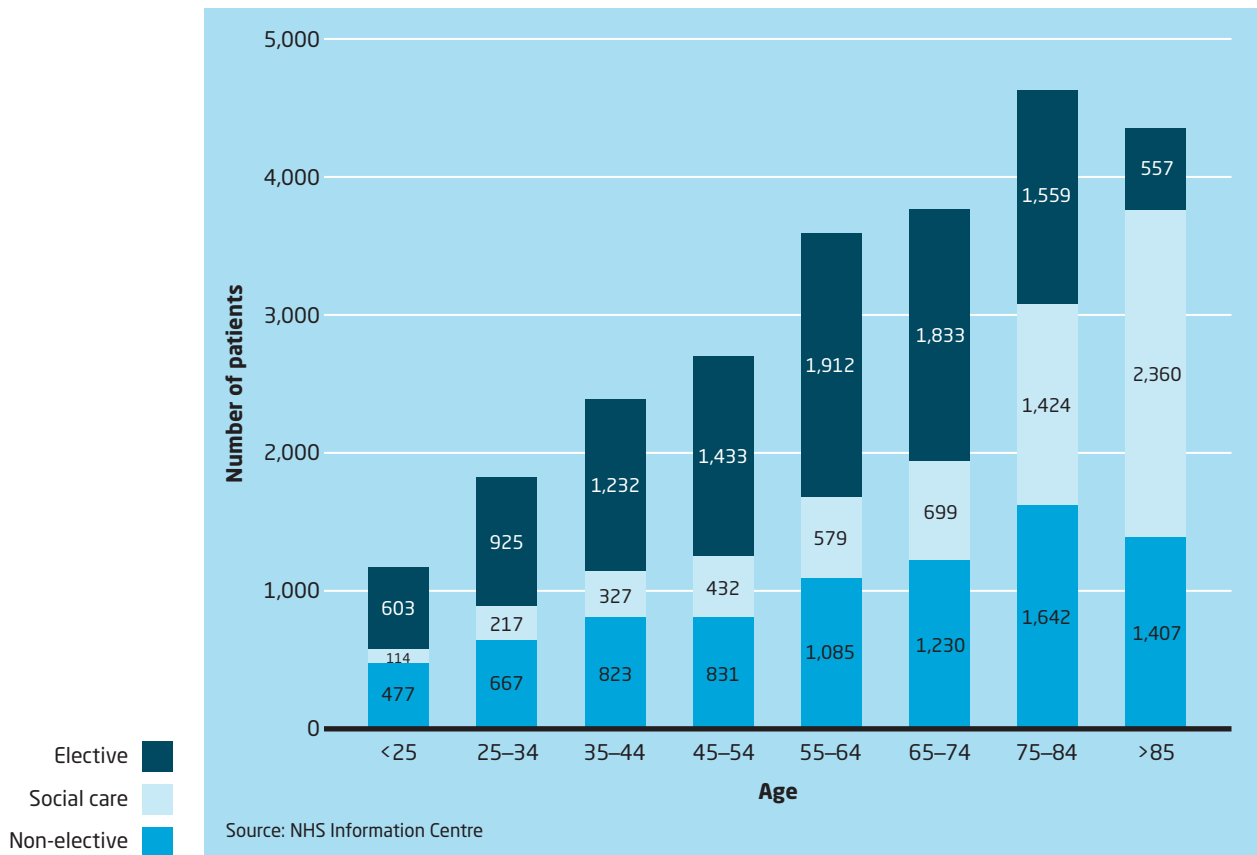
It is essential for councils and their health partners to develop a good understanding of the needs of their population, especially those segments from which the most intensive users of health and care services are likely to originate. This requires a clearer analysis of the reasons behind the wide variations in spending, costs and outcomes from one area to another. Their performance should be benchmarked against appropriate local, regional and national comparators. It is important that the experience of people who use local health and care services is drawn upon. Developing this intelligence with health partners should enable a better shared understanding of the reciprocal impact on the local health service where wide variations can be seen in such areas as emergency hospital admissions, delayed discharges and continuing care. It follows that the focus should then be on how health and social care resources can be used together and their combined impact, for example, in Torbay (*see* Case study and Figure 10 opposite). The methodological difficulties in identifying the specific effects of social care spending on the NHS (or vice versa) should not divert attention from what can be achieved by joint use of resources.

Locally an immediate priority for councils and their NHS partners will be to use their allocation of the £648 million, made available in 2011/12, to invest in social care services to benefit health and to improve overall health outcomes. The Operating Framework makes it clear that locally this allocation should be transferred to local authorities via an agreement under Section 256 of the 2006 Health Act (Department of Health 2010). Existing financial

Case study: Torbay

Torbay is building on its existing achievement in integrating health and social care that has improved access to care services and achieved substantial reductions in the use of hospitals and residential and care homes. It is developing better ways of identifying and understanding the needs of people who are intensive users of both health and social care, so that preventive spending and service redesign can be targeted accordingly. This involves mapping usage, costs and outcomes across acute, community, primary and social care services, and developing better pathways for people with complex needs over the age of 85 years.

Figure 10 People accessing services – Torbay Care Trust



arrangements such as pooled budgets will need to be reviewed with a view to protecting existing achievements and ensuring the smooth migration of joint agreements to GP consortia.

Aligning local resources

Based on a better understanding of local needs, the case for a much closer alignment of health and social care resources is overwhelming. Despite exhortations to co-ordinate resources, less than 5 per cent of combined NHS and public social care budgets are spent through joint arrangements. There is a variety of ways in which local budgets could be pooled, including the existing powers under Section 75 of the Health Act; the community budget approach proposed in the Spending Review; or place-based budgeting put forward by the Local Government Association, which in turn draws on the experience of HM Treasury’s Total Place pilot programmes (Humphries and Gregory 2010). The actual

mechanisms used to jointly fund services are less important than clarity about the desired outcomes (Audit Commission 2009). A radical option would be to merge local adult social care budgets with GP consortia commissioning budgets – for defined needs or patient/user groups – to enable a completely integrated local approach to the funding and commissioning of services.

Work in Birmingham and Coventry has demonstrated the potential benefits of aligning resources with care pathways at a whole system level (*see example in box below*).

Example: Aligning resources with care pathways

Optimal outcomes project – PricewaterhouseCoopers LLP

1. Map existing pathways across the care economy from the perspective of the service user/patient.
2. For each process step allocate a quantity/cost value and identify the outcomes currently being achieved.
3. Review and evaluate national and international research on prevention and early intervention to determine the evidence base for investment in such activities.
4. In partnership with local clinicians, practitioners and service users design a citizen led ‘optimal’ care and health pathway focused on delivering better outcomes.
5. Map the new optimal pathway allocating quantity/cost values.
6. Apply impact assessment of changes using financial modelling and predictive actuarial modelling techniques.
7. Prepare investment model showing when and where savings will flow from each of the interventions.
8. Build benefits realisation model and business case for change.
9. Agree risk reward approach for care economy possibly using social bonds as an investment vehicle.
10. Implementation plan and benefit management strategy.

Topic	Areas for savings		Potential saving (£m)
	Health	Social care	
Dementia	High	High	£33.9
Stroke	High	High	£12.6
Mental health disorders	High	Low	£20.7
Coronary	High	Low (except for over 65s)	£4.5

Source: PricewaterhouseCoopers, unpublished

The wider role of local government – health and well-being

The importance of other local government services in contributing to better health outcomes should not be overlooked. Eighty-five per cent of older people do not use council care services but may use other services such as housing, leisure and adult education. These can play an important role in enabling people to live healthier, more independent lives and contribute to the well-being of communities, reducing the need for both health and care services (Social Care Institute for Excellence 2010). The contribution of housing to mental and physical health and well-being is well recognised

and has a critical contribution to make to the value and effectiveness of the health and care systems (Department of Communities and Local Government *et al* 2008). There is growing interest in the emergence of housing-based models of care such as extra-care housing and the potential of these schemes to enable independent living and prevent inappropriate admissions to hospital and long-term care. Since the separation from children's social care from 2004, adult social care increasingly sits alongside many of these and other services within local government.

Councils have to achieve a balance between the attention they give to social care services for those with high needs and the promotion of active ageing that will reduce or delay the onset of those needs. Strategies for prevention and early intervention can drive down the total costs of provision for an ageing population, without compromising objectives for dignity or independence (Audit Commission 2010). There is an opportunity here for the proposed local Health and Well-being Boards to oversee a more strategic approach that builds on existing joint strategic needs assessments. The new Boards should be well placed to take an overall view of how resources are used across all parts of the local health and care system and to what effect.

Implications for policy and practice

Policy-makers and regulators should:

- assess the long-term resource needs of health and social care as a single whole system instead of separate services, supported by a place-based approach to understanding overall needs and resources
- consider how the financial settlements for the NHS and local government could be better synchronised to make it easier to configure joint planning of resources
- ensure that national frameworks for outcomes, accountability, performance and regulation encourage rather than inhibit the closer alignment of NHS, social care and local government resources
- clarify how the respective roles of the national NHS Commissioning Board, GP Consortia and local Health and Well-being Boards will be triangulated.

Councils and their NHS partners should:

- protect existing achievements, such as jointly funded services and other Section 75 agreements, and see how these could migrate to GP consortia with options for further alignment of resources using place-based budgeting and other approaches
- identify local pressure points, for example, continuing care, emergency admissions of older people and special placements, and see how these will be monitored and managed with jointly agreed contingency plans for winter pressures
- develop a better understanding of how resources are being used across the health and care interface and how local performance, costs and outcomes look against national comparators with a set of shared metrics to manage and measure performance to inform the joint strategic needs assessment
- agree how the local allocation of the £1 billion assigned to the NHS to support social care can best be used to enhance health and social care outcomes by identifying those areas of NHS investment in social care that will have the greatest impact
- ensure that these actions are driven by open dialogue and conversations between local leaders including key players in GP consortia so that system leadership is not lost in the transition to the new structures.

Appendix: Estimate of social care funding gap: 2011/12 to 2014/15

Social care spending		Middle scenario 7% real cut by 2014/15	Plus PSS real growth above 2010/11	Plus NHS transfer to social care	Required funding to meet needs	Funding 'gap' 7% real cut (col 5 - col 6)	0% real cut	1.4% real cut
Cash (£m)	2010/11 prices (£m)	2010/11 prices (£m)	2010/11 prices (£m)	2010/11 prices (£m)	2010/11 prices (£m)	2010/11 prices (£m)	2010/11 prices (£m)	2010/11 prices (£m)
col 1	col 2	col 3	col 4	col 5	col 6	col 7	col 8	col 9
2004/5	13,403							
2005/6	13,945							
2006/7	14,230							
2007/8	14,111							
2008/9	14,470							
2009/10	14,489 ^a							
2010/11	15,072 ^a							
2011/12		14,831	15,389	16,174	15,449	725	966	484
2012/13		14,590	15,490	16,353	15,835	518	1,000	36
2013/14		14,349	15,286	16,315	16,468	-154	569	-876
2014/15		14,108	14,986	15,897	17,127	-1,230	-267	-2,194

^a Spending estimated as average growth over 2004/5 to 2008/9: 3.8% pa.

Data sources/definitions/assumptions

Col 1. Net social care expenditure, including Supporting People Grant and Personal Social Services Grant The Health and Social Care Information Centre (2010) Personal Social Services Expenditure and Unit Costs England, 2008-09 Table 3.1 Personal Social Services grant: Department of Health (2009) Department Annual Report www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_100667

Col 2. Social care spending at 2010/11 prices, deflated using GDP deflator

Col 3. Estimated future social care spending assuming 7% real cut by 2014/15 (assumes PSS grant element *not* subject to 7% cut)

Col 4. As above plus real growth in PSS grant over and above 2010/11 level

Col 5. As above plus NHS contribution to social care

Col 6. Estimated future social care spend required to cover growth in needs and unit costs (ADASS and LGA, assumes 4% real growth per annum for 2013/14 and 2014/15, but for 2011/12 and 2012/13 2.5% on assumption of the impact of public sector pay freeze)

Cols 8/9. Funding gaps calculated on alternative assumptions about future social care funding. Spending figures not presented in the table, but are based on: no real cut (0%) and 1.4% real cuts over four years.

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