

The state of social care:

the reality of a fragmented system

Some clinical commissioning groups, handed responsibilities by the 2012 Health and Social Care Act, were convinced that proactive, integrated care closer to home was the answer. Inspired by reported success in places such as Torbay,¹ GPs were going to wrap a holistic package of health and social care around frail older people.

They predicted that patients and their families would plan for crises in advance and hospital admissions would fall. Frail older patients would be discharged earlier and delayed transfers of care would be a thing of the past, with Emergency Frailty Units providing rapid and comprehensive geriatric assessment with early discharge home. Joining with social care in a virtuous circle of quality improvement, hundreds of hospital beds could be closed and the money invested in care closer to home.

ENGAGING WITH SOCIAL CARE

Local authorities with social care responsibilities put in place a range of programmes to reduce costs, review commissioning, and coordinate services across public health and social care. NHS Better Care Funds were settled on social care departments. Many wished this engagement might lead to marriage and sustainability ever after.

Draft NHS Sustainability and Transformation Plans (STP) built on these foundations. Leicestershire's was published in November 2016 and promised the closure of 281 hospital and community beds. They would not be needed.

Allied to Better Care, Leicestershire's ambitious new Help to Live at Home service was launched in November 2016. Rather than spot-purchasing personal social care packages from a multiplicity of small providers, Leicestershire County Council (LCC) rationalised its contracts, giving responsibility for one district to one provider. This innovative service model would enable a stronger relationship between the purchaser and provider. It would facilitate outcome-based contracts and reward proactive care.²

Doubts about this happy ending were raised in this journal as early as 2014, with Stephen Gillam warning, 'no government can indefinitely ignore the hard choices needed to prevent a decline in England's health and social care'.³

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Despite a myriad of 'successful evaluations' of admission avoidance schemes,¹ the numbers of older people accessing secondary care for urgent care problems increased year on year,⁴ casting doubt on the initial assumptions.⁵ More recently, schemes, pushed heavily by successive English governments, which aimed to try to 'proactively manage' older people with the subtext of preventing admissions, have failed to evidence impact. The most robust evaluations undertaken (notably in the Netherlands, not the UK) have failed to show cost-effectiveness.⁶

A FRAGMENTED SYSTEM

Sir Andrew Dilnot's proposed reforms to the funding of social care, due to be implemented in 2017, have been quietly shelved, the administrative costs considered unaffordable. Concealed behind the political arras of public sector 'efficiency', cuts to the revenue support grant provided to local government have quietly eroded 30% of council budgets.

Autumn 2016 saw the King's Fund criticising proactive care for its idealism, 'highlighting the growing divide between the policy rhetoric of "care closer to home" and the reality of a fragmented system'.⁷

Squeezed and squeezed, at some point the pips squeak. In our own county, the 'stronger relationship' with Leicestershire's Help to Live at Home care providers was not a one-sided affair. Just prior to the launch, the biggest provider found itself without the staff needed to service the contract. LCC found itself suddenly responsible for a cohort of frail older people with no identified professional care.²

Despite the best efforts of the hospital

discharge team, the crisis led to a backwash of delayed transfers of care leaving frail older patients stranded in hospital with no care package at home.

Was this crisis 'unfortunate' or a predictable risk? The King's Fund had warned that:

*'Reductions in central government grants to local authorities have been passed on to care providers in the form of reduced fees, or below inflation increases, squeezing their incomes so much that some are now stepping back from providing care to people funded by councils.'*⁷

Stephen Gillam, in this journal, had predicted the need for a new financial settlement for social care.³ Of the suggestions discussed, raising taxation and reducing eligibility have already happened. Councils, usually allowed to raise local taxes by a maximum of 1.99%, were given permission to add a further 2% 'social precept'.

After ignoring health and social care in its Autumn Statement, there was increasing pressure on the Treasury to recognise that the 2% social precept would not bridge the yawning financial gap. A hurried pre-Christmas change of heart by the government now allows councils to bring forward this 2% rise in council tax, as long as they keep to a maximum total rise of 6% over 3 years.

Politics aside, it is clear to all that something must be done. Cuts in social care are now impacting on the sustainability of the NHS. The Care Quality Commission, in its report *The State of Health Care and Adult Social Care in England 2015/16*, considers that:

"... the crisis led to a backwash of delayed transfers of care leaving frail older patients stranded in hospital with no care package at home."

"Cuts in social care are now impacting on the sustainability of the NHS."

*'The fragility of the adult social care market and the pressure on primary care services are now beginning to impact both on the people who rely on these services and on the performance of secondary care. The evidence suggests we may be approaching a tipping point. The combination of a growing and ageing population, people with more long-term conditions and a challenging economic climate means greater demand on services and more problems for people in accessing care. This is translating to increased accident and emergency attendances, emergency admissions, and delays to people leaving hospital, which in turn is affecting the ability of a growing number of trusts to meet their performance and financial targets.'*⁸

UNFAIR FUNDING FOR SOCIAL CARE

Adding 2 or 3% to rising council tax bills is not only an inadequate response. It is also an inequitable one. At an individual level, council tax correlates poorly with ability to pay. In England, the core spending power available to authorities responsible for social care also bears little relationship to the level of community need.⁹

Faced with the choice of making unacceptable cuts to social care or setting an illegal budget, councils can conduct a local referendum asking voters for their permission to raise the double-digit percentage increases needed to plug the gap.

Doing so a matter of months before most upper-tier authorities prepare for election is a high-risk strategy. Will councillors really want to go up before a fickle electorate promising to increase council tax by amounts the *Daily Mail* describes as 'eye-watering'?

Council tax is not the only source of income available to authorities responsible for social care. As the government Revenue Support Grant withers away to nothing, councils are becoming increasingly dependent on alternative sources of income. Business rates, planning fees, and the New Homes Bonus reward the most successful and entrepreneurial councils. As in the game of Monopoly, the inverse care law applies.

Kensington and Chelsea, for example, has relatively low levels of deprivation and a lower

than average percentage of the population aged >65 years. Thanks to alternative funding streams, including inner London parking charges, it has twice the core spending power of the lowest-funded authorities with responsibility for social care. One of these low-funded councils is Leicestershire.⁹ As the King's Fund has pointed out:

*'Access to social care increasingly depends on what people can afford — and where they live — rather than on what they need. This favours the relatively well off and well informed at the expense of the poorest people, who are reliant on an increasingly threadbare local authority safety net.'*⁷

Social care funding in England is currently opaque, impenetrable, and increasingly inequitable. Society as a whole also needs to review its health priorities. Is it always cure, or is there a need to move more towards care? At all ages, we currently spend around 50% of health budgets in the last 6 months of people's lives, often on expensive investigations and treatment with marginal benefits.

Clinicians and patients need to see health and social care move away from rhetoric-based policy to an evidence-based approach, even if the messages are not always palatable.

We need to align good ideas with improvement-based development and robust evaluation. We need to establish a national health and social care service on a sustainable long-term footing so that vulnerable people can live with dignity and safety.

Theresa Eynon,

Part-Time Salaried GP, Heath Lane Surgery, Earl Shilton, Leicestershire. Elected Member and Labour Health Lead, Health Overview and Scrutiny Committee, Leicestershire County Council, Leicester.

Simon Conroy,

Consultant Geriatrician, University Hospitals of Leicester NHS Trust. Honorary Professor, University of Leicester, Leicester.

Provenance

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ADDRESS FOR CORRESPONDENCE

Theresa Eynon

Heath Lane Surgery, Heath Lane, Earl Shilton, Leicestershire LE9 7PB, UK.

Email: t.eynon@nhs.net

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