

ADULT SOCIAL CARE FUNDING

STATE OF THE NATION 2017

OCTOBER 2017





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Foreword

All eyes will be on Philip Hammond on 22 November for his first Autumn Budget. When announcing the date, the Chancellor described the financial statement as the moment when he will set out the Government's plans for "raising the taxes that we need over the coming years, and how we intend to spend them to support our public services." Local government will be desperately hoping the Autumn Budget delivers short- and long-term support for one of our most vital public services: adult social care.

There is some cause for cautious optimism. The Chancellor's Spring Budget delivered an additional £2 billion for adult social care over the period 2017/18 to 2019/20. And, as the experience of the 2017 General Election demonstrated, recognition of the need to secure the immediate and future stability of the service is growing all the time, not least amongst national politicians.

But experience over a longer time period inevitably tempers that optimism, and inertia remains the characteristic we typically associate with the prospects for future funding and reform of adult social care.

It's not for want of trying. The 'longer time period' could go back 20 years to the then government's 'Modernising social services' white paper. Since then, governments of all colours, along with several notable independent commissions and reviews, have attempted to plot a path for securing the sustainability of adult social care. But, for various reasons, those paths have become overgrown with the long grass that so often scuppers attempts at change in this public policy area.

This simply cannot continue. Adult social care is recognised – nearly universally so – as being in crisis right now, with the future outlook no brighter. Funding pressures are mounting, with very real consequences for the entire system and particularly the very people the service is there to support. Therefore, in this edition of our annual state of the nation report, we look in part at people's experience of care and support.

Part of the policy response to the challenges facing social care continues to be closer working with our partners in the NHS. Rightly so. But over the last year, that relationship has undoubtedly become strained as the ambition for integration has struggled to be enough of a driving force to overcome the barriers associated with the reality of health and care pressures on the ground and the national response to them.

Delayed transfers of care (DTOC) have become a dominant preoccupation of that reality, but the focus on councils' role in reducing them has not been balanced. Our report therefore also explores what is really happening on the DTOC agenda. In the interests of people needing long-term support, we must not allow the whole agenda for social care to be dominated by this issue. Instead we must ensure that social care is recognised as a vital service in its own right, and that its value and core purpose is in helping people to live independently and supporting their wellbeing.

Councils have a proud record of getting on with the job of delivering for their local residents, and doing so in partnership, even in the most testing of circumstances. But it is no exaggeration to say that the circumstances are now veering steadily towards the impossible. For adult social care to thrive we therefore need Government to act both for the here and now, and for the longer-term. I hope this publication encourages such action so that high quality, person-centred and safe care can be secured for all those who need it.



Cllr Izzi Seccombe OBE

Chairman, Community Wellbeing Board
Local Government Association (LGA)

Key points

- English councils will have managed reductions to their core funding from national government totalling £16 billion between 2010 and 2020. Councils are protecting adult social care but it is impossible for the service to be immune from the impact of reductions on this scale.
- The LGA estimates that local government faces a funding gap of £5.8 billion by 2020. £1 billion of this is attributable to adult social care and includes only the unavoidable cost of demography, inflation and the National Living Wage. This figure excludes other significant pressures, including the potential costs associated with 'sleep-ins', which include both historic liabilities and future costs, as well as any resources to address unmet need.
- In addition to the £5.8 billion gap by the end of the decade, a bare minimum of £1.3 billion is required immediately, and in future years, to stabilise the adult social care provider market.
- The consequences of underfunding include an ever more fragile provider market, growing unmet need, further strain on informal carers, less investment in prevention, continued pressure on an already overstretched care workforce, and a decreased ability of social care to help mitigate demand pressures on the NHS.
- The Government's response to the challenge of adult social care funding in recent years has been short-term and incremental in nature. One off grants, the council tax precept and increases in improved Better Care Fund (BCF) funding have been helpful. But each mechanism has its limitations and they do not deal with all short-term pressures, let alone address the issue of longer-term sustainability.
- The LGA has particular concerns with developments linked to the £2 billion for adult social care announced in the 2017 Spring Budget. There is now disproportionate emphasis on one of the three grant conditions attached to the funding, "reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready".
- Councils are committed to reducing DTOC and work closely with local health and care provider partners to get people out of hospital and back into the community. Any suggestion, implied or otherwise, that councils do not take this responsibility seriously is deeply unhelpful and damaging to local relationships.
- Local government remains committed to the integration of health and care in the interests of ensuring joined-up services that achieve the best outcomes for individuals requiring services. But without question, the Government's main vehicle for driving integration forward operationally – the BCF – has lost credibility. Far from giving practical manifestation to the ambition of integration, the BCF has only served to recast that ambition in increasingly narrow terms.

Building a better adult social care system

- Government should address the £5.8 billion funding gap facing local government by 2019/20.
- Government must immediately meet the £1.3 billion pressure to stabilise the social care provider market, through further business rates retention or new grant funding. Other unfunded pressures facing adult social care, such as sleep-ins, should be met by Government in full.
- In dealing with the pressures facing social care and health in the short and long-term, the Government must develop a balanced approach that does not give one part of the system primacy over the other.
- Government needs to be realistic in its approach to DTOC and demonstrate greater recognition of: the pressures facing social care; its continued efforts to improve performance; and its intrinsic value in its own right in supporting independence and wellbeing.
- An effective response to tackling DTOC – as with any system-wide issue – must consider the whole system. Without investment in primary, community and social care services to prevent people having to go into hospital unnecessarily in the first place, the vicious circle will continue in which we seek to treat the symptoms rather than the causes of system pressures.
- We now need a new approach that moves beyond the BCF and allows local areas to agree long-term plans for integration, with funding for social care going directly to councils.

Local government funding overall

It is impossible to consider the state of funding for adult social care without first considering the state of local government funding overall. The LGA estimates that English councils will have managed reductions to their core funding from central government totalling £16 billion between 2010 and 2020. To put that into perspective, budgeted expenditure for adult social care for this financial year, 2017/18, stands at £15.6 billion.

Based on an assessment of potential future increases in demand for services, plus the costs of service delivery, the LGA estimates that local government faces a funding gap of £5.8 billion by 2020.

£1 billion of this is attributable to adult social care and includes only the unavoidable cost of demography, inflation and the National Living Wage. In addition to the £5.8 billion gap by the end of the decade, a bare minimum of £1.3 billion is required immediately, and in future years, to stabilise the adult social care provider market

Figure 1: Local government funding gap by 2019/20 / £ billion

Service area	Funding gap by 2019/20, £bn
Children's services	2.0
Adult social care (inclusive of the pre-existing pressure to stabilise the adult social care provider market)	2.3
Homelessness and temporary accommodation	0.2
Other services funded from council core spending power	2.4
Apprenticeship levy	0.2
Total	7.1 (£5.8bn funding gap by 2019/20 plus £1.3bn to stabilise the adult social care provider market)

The LGA estimates that English councils will have managed reductions to their core funding from central government totalling £16 billion between 2010 and 2020.

It must also be noted that these figures are a minimum, based solely on current responsibilities and costs. They do not account for either new costs that are outside the control of local government, or new burdens imposed by national government. Such additional costs will include, for example, local government pay and the National Living Wage, the very live issue of remuneration for care worker 'sleep-ins' (further information below), and long-term costs of implementing as yet unknown recommendations expected from the independent inquiry following the Grenfell Tower tragedy. Of further importance, the funding gap for adult social care does not include any costs associated with provision for existing unmet, or under-met, need.

Government must address the £5.8 billion funding gap facing local government by 2019/20. And it must immediately meet the additional and annually recurring £1.3 billion pressure to stabilise the social care provider market, through further business rates retention or new grant funding. Other unfunded pressures facing adult social care, such as sleep-ins, should be met by Government in full.

This wider context is important as it partly explains why adult social care is under such enormous pressure and looks set to continue being under pressure for the foreseeable future. According to the Association of Directors of Adult Social Services (ADASS) 2017 budget survey¹, adult social care accounts for a growing proportion of councils' total budgets, (for the 152 councils with adult social care responsibilities) – up from 35.6 per cent in 2016/17 to 36.9 per cent in 2017/18. The survey shows that councils are protecting adult social care funding, but when they face the challenge of making significant savings to balance their books, it is impossible for adult social care to be immune from having to make its own significant contribution to those savings.

Adult social care accounts for a growing proportion of councils' total budgets – up from 35.6 per cent in 2016/17 to 36.9 per cent in 2017/18.

1 'ADASS budget survey 2017', Association of Directors of Adult Social Services, June 2017 www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf

Adult social care funding

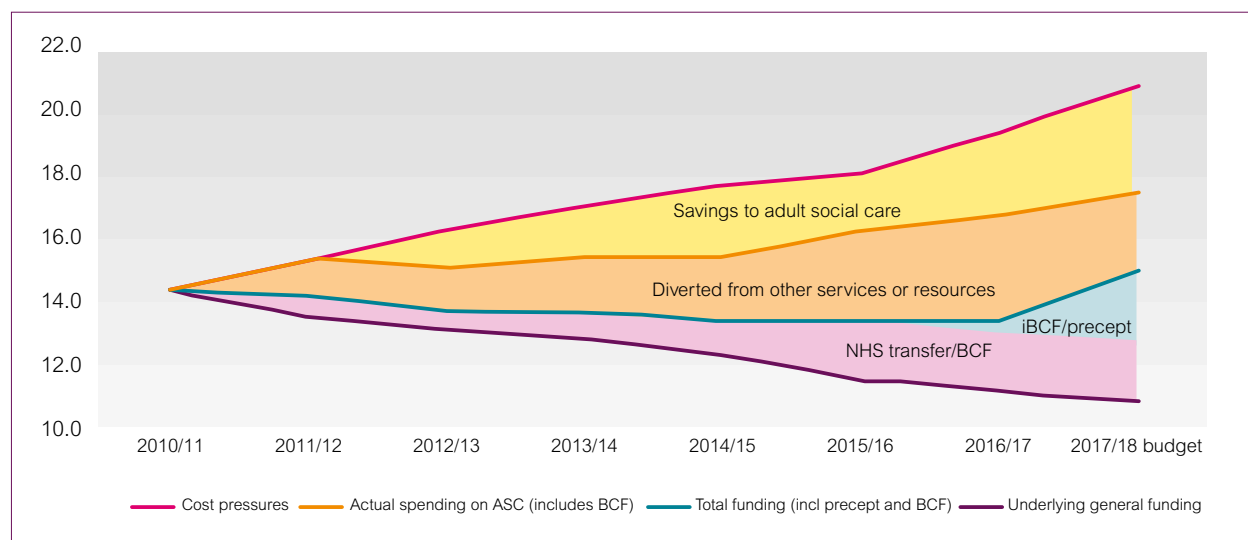
Pressures, the case for investment, and the Government's response

In recent years, adult social care spending has been kept under control through a mix of service savings, disproportionate reductions to other services, the NHS transfer/BCF and, most recently, the social care precept.

In the chart below, 'cost pressure' is what we estimate councils would have had to spend on adult social care if they had not made efficiency savings. The difference between this and 'Actual spending on ASC (including BCF)' is the amount councils have had to save from adult social care budgets to maintain spending at roughly 2010/11 levels. However, this is only one side of the picture. 'Underlying general funding' shows how much money councils would have had available to spend on adult social care if they had spread unringfenced funding reductions equally across all services.

It is therefore clear that the gap has in fact been met through a combination of the NHS transfer/BCF and disproportionate savings from budgets of other council services. In other words, councils have clearly prioritised adult social care and support services but this is inevitably and unavoidably to the detriment of other local services. Every council will have made their own decisions in this process but it is safe to assume that the services that had to deal with deeper reductions to funding would have included things like libraries, leisure, and bus services. This is clearly a false economy given these universal neighbourhood services are preventative in the widest sense and contribute to wellbeing.

Figure 2: How adult social care spending has developed, 2010-17



Over the last two years, the Government’s response to the challenge of adult social care funding has been short-term and incremental in nature. Consequently, additional resource capacity is not a straightforward picture – at least not in terms of being able to take a figure at face value. To illustrate this point, consider the following statement by Rt Hon Sajid Javid MP in relation to the additional £2 billion announced for adult social care at the 2017 Spring Budget:

Over the last two years, the Government’s response to the challenge of adult social care funding has been short-term and incremental in nature.

“This additional money [the £2 billion]...will make an immediate difference to people in our communities who need care and support, and it will bring the total dedicated funding available for adult social care in England to £9.6 billion over the course of this Parliament.”²

This figure (or a slight variation of it) has been used several times by Government in recent months in response to claims that social care does not have the funding it needs. But the number is not as simple as it seems. The following table sets out how we believe the figure breaks down:

Figure 3: £9.6 billion for adult social care 2017/18 to 2019/20? A possible explanation

£ million	Source	2016/17	2017/18	2018/19	2019/20	TOTAL
Adult social care precept	2015 Spending Review (revised at 2017/18 Local Government Finance Settlement)	382	1,023	1,734	1,797	4,936
Adult Social Care Support Grant	2017/18 Local Government Finance Settlement		241			241
iBCF	2015 Spending Review		105	825	1,500	2,430
Increase to iBCF	2017 Spring Budget		1,010	674	337	2,021
TOTAL		382	2,379	3,233	3,634	9,628

2 Parliamentary Budget resolution debate, Rt Hon Sajid Javid MP, March 2017 <https://hansard.parliament.uk/Commons/2017-03-09/debates/C2A7F416-1A88-4896-93DD-A857967F3401/BudgetResolutions>

Each component part of the £9.6 billion warrants a degree of further exploration to expose its limitations and flaws.

The adult social care precept: The precept was first introduced in the 2015 Spending Review and allowed councils to raise an additional 2 per cent through Council Tax above the existing threshold of 1.99 per cent for base Council Tax (beyond which a referendum is required to approve higher increases). The 2017/18 Local Government Finance Settlement subsequently introduced greater flexibility, allowing councils to levy a 3 per cent precept.

However, the further flexibility with the precept does not change the total allowable increase from 2017/18 to 2019/20, which is capped at 6 per cent. This move therefore only provides a small degree of additional help by front-loading some of the resource capacity. This partially offsets concerns that the iBCF funding announced in the 2015 Spending Review is heavily back-loaded.

Furthermore, the precept unfairly shifts the burden of tackling a clear national crisis onto councils and their residents. And this is after years of councils being encouraged to keep Council Tax as low as possible, or frozen.

If a council with social care responsibility used the precept flexibility in all four years (and also the 1.99 per cent core increase), 7p of every £1 of council tax will be precept funding by 2019/20. By the same point, councils could be spending as much as 38p of every £1 of council tax on adult social care, up from just over 28p of every pound in 2010/11.

Adult Social Care Support Grant (ASCSG): The ASCSG was announced in the 2017/18 Local Government Finance Settlement and followed the 2016 Autumn Statement, which failed to even mention adult social care. As with the changes to the precept, the funding helps counter the back-loading of the iBCF funding announced in the 2015 Spending Review.

However, the ASCSG is for one year only and, most importantly, it is not new money. It was instead created from savings of equivalent value from the New Homes Bonus (NHB) and was therefore simply a redistribution of funding already promised to councils. The 'switch' from NHB to ASCSG left all district councils worse off and also left around a third of social care councils worse off as they lost more in NHB payments than they gained from the ASCSG.

Improved Better Care Fund (iBCF): Additional funding through the iBCF is significant and welcome. However, by being routed through the BCF the funding is now subject to a concerning degree of oversight and influence from both Government and NHS England. The funding also reduces by a third each year and stops at the end of 2019/20. Issues with the iBCF are explored in further detail below.

All recent efforts to support adult social care are welcomed and this commentary is not intended to downplay the significance of the additional investment for the service. It has, without question, gone some way to alleviating the significant pressures facing the care and support sector.

Crucially however, the limitations of the funding means that it does not address all short-term pressures as evidenced below. Furthermore, as the funding is not in councils' baselines and cannot therefore be called on in future years, it is impossible to plan, or give assurances, for beyond 2020. This makes it difficult to, for instance, use this money for permanent increases in provider fees, which adds further instability into an already unstable market.

The immediate outlook for adult social care funding

The LGA estimates that adult social care faces a growing annual funding gap over the next three years, despite the investment outlined above:

Figure 4: Adult social care funding gap, 2017/18 - 2019/20

£ billion	2017/18	2018/19	2019/20
Funding gap	1.1	1.9	2.3

The gap of £2.3 billion by the end of the decade comprises two main elements. First, £1 billion of core pressures linked to demography, inflation and the National Living Wage. And second, a minimum annually recurring figure of £1.3 billion to stabilise the provider market – in other words, the amount needed to close the gap between what social care providers say they need and what councils currently pay.

The additional resources councils can call on have certainly limited the scale of the challenge for this financial year. But there is still a gap of over £1 billion this financial year, and over the next two years the gap widens again.

The limitations of the funding means that it does not address all short-term pressures.

In the spotlight: sleep-ins

As set out above, the LGA's estimate of the funding gap facing council services does not include other potential costs that are likely to arise, one of which – and which is of real and growing concern – is the cost of 'sleep-ins'.

At the heart of this issue is whether sleep-ins (when a care worker is permitted to sleep at a place of work) should be considered as working time and, as such, attract the National Living Wage (NLW). The concern, and confusion, stems from the fact that guidance on calculating the NLW for sleep-ins from the Department of Business, Energy and the Industrial Strategy (BEIS) directly contradicts the 2015 National Minimum Wage (NMW) regulations. In determining what counts as 'working time', the latter states that workers are only entitled to be paid for the time they are awake. This is at odds with the former, which states that a worker, even if asleep, is entitled to the NMW or NLW for the entire time they are at work.

In July, the Government announced that it would waive the financial penalties faced by employers who are found to have underpaid their workers for sleep-in shifts. However, the Government also confirmed that any employer underpaying their staff for these shifts in the future will be liable to pay financial penalties equating to 200 per cent of the arrears found.

This issue goes well beyond underpayment penalties and also includes underpayment back-pay. At the time of writing, employers face the prospect of having to make back-payments for underpayment of sleep-in shifts dating back six years. Enforcement activity is being led by HM Revenue and Customs, although the Government's July announcement suspended this activity until 2 October 2017 to allow further discussions between Government and the care sector. In September, the Government announced this suspension of enforcement activity would be extended for one month.

The potential costs of sleep-ins back-payment are significant. According to one survey by Cordis Bright, back-pay costs just within the learning disability sector could total £400 million³. Going forwards, the annual cost facing the learning disability sector could be in the region of £200 million a year. The future cost impact will be more than just the pure top up cost. For instance, if time spent asleep is considered working time then some working shift patterns may not be compliant under the Working Time Directive. More staff will therefore be needed to cover such shifts, exacerbating existing recruitment difficulties and potentially driving up costs because agency staff will be required.

Of equal concern is the potential liability facing people who employ personal assistants through direct payments. Based on a 2016 National Audit Office report⁴ on personalised commissioning in adult social care, 500,000 individuals with a care need, and 100,000 carers with a support need, paid for services via a personal budget allocated to them by their local council.

According to a 2014 ADASS personalisation survey⁵, 24 per cent of these personal budgets were allocated as a direct payment for the individual or carer to organise and pay for their own care or support. In a 2015 sample, the most common way for people to use their budget was on care and support services (59.6 per cent), followed by personal assistants (48.3 per cent).

Discussions continue with Government and partners. The LGA is clear that:

1. Sleep-in costs pose a significant risk to an already fragile and unstable provider market, creating uncertainty and concern for people using services and their families, and the paid workforce which delivers those services.
2. Any policy and/or legislative decisions need to be fair to workers, employers, commissioners and individuals who receive care, including those who directly pay for care themselves either through a council-funded personal budget or through private means.
3. Government must provide funding to enable the back-pay liability to be met without jeopardising the provision of care and support – particularly given the Government's own recognition that previous written guidance was "potentially misleading".
4. Additional and genuinely new funding must be made available to councils so they can ensure that providers and individuals in receipt of direct payments have the means to pay the correct level of wages going forwards.
5. The additional £2 billion for adult social care in the 2017 Spring Budget was not announced with sleep-in costs in mind. Government must therefore not expect this vital funding to be used to cover these costs.

3 See for instance, 'Future of learning disability care in the UK hangs in the balance', Mencap, September 2017, www.mencap.org.uk/press-release/future-learning-disability-care-uk-hangs-balance

4 'Personalised commissioning in adult social care', National Audit Office, March 2016, www.nao.org.uk/wp-content/uploads/2016/03/Personalised-commissioning-in-adult-social-care-update.pdf

5 'ADASS personalisation survey 2014', Association of Directors of Adult Social Services, 2014, www.adass.org.uk/media/4692/adasspersonalisationsurveyreport03102014.pdf

Faced with a growing funding gap, directors of adult services are predicting another difficult year ahead. As the 2017 ADASS budget survey shows, councils intend to make savings of £824 million in 2017/18, continuing the trend of significant annual savings within adult social care during the course of the current decade. ‘Savings’ in this sense means both efficiencies to counter pressures such as demography and inflation, as well as reductions.

Figure 5: Annual adult social care savings, 2011/12 – 2017/18

Year	Savings / £ million
2017/18	824 (planned)
2016/17	941
2015/16	1,100
2014/15	850
2013/14	800
2012/13	890
2011/12	991

As the ADASS survey also shows, this year’s savings follow a budget overspend of £366 million in 2016/17, considerably higher than the previous year’s £168 million overspend.⁶

Despite these savings, councils are protecting adult social care. Adult social care savings account for 27 per cent of councils’ overall savings, which is notably smaller than the 37 per cent of councils’ overall budget spent on social care. But, of course, making this level of savings is not straightforward. The ADASS survey illustrates that only 31 per cent of directors are ‘fully confident’ of meeting their savings target this year, dropping to just 8 per cent next year, and 7 per cent the year after that.⁷

Savings on this scale will clearly also have wide-ranging consequences, and at the most fundamental level, the ability of councils to meet statutory duties will inevitably be tested. Just 29 per cent of directors are ‘fully confident’ in the ability of their service to meet statutory duties, a figure which again drops in the next two years; to 4 and then 3 per cent.⁸

6 See 1

7 Ibid.

8 Ibid.

On the ground the consequences of under-funding are now well-known and include an ever more fragile provider market, growing unmet need, further strain on informal carers, continued pressure on an already overstretched care workforce, and a decrease in social care’s ability to help mitigate demand pressures on the NHS.

Funding pressures are also impacting on investment in the number one priority area directors have identified for helping to meet the savings challenge: prevention. Spend on prevention in 2017/18 forms 6.3 per cent of adult social care budgets, or £890 million. This is a smaller proportion of the budget than last year (7.1 per cent), and a decrease in cash terms from last year (£954 million).⁹

Only 31 per cent of directors are ‘fully confident’ of meeting their savings target this year, dropping to just 8 per cent next year, and 7 per cent the year after that.

9 Ibid.

Adult social care: the individual's perspective

The consequences of underfunding described above are significant and matter most to the individual requiring care and support. The following case studies describe what life is like for real people who use, or have recently used, care and support services. They are a powerful reminder of why social care matters and its fundamental value. And they bring to life, often in stark terms, the reality of different elements of our care system – both the good and the bad – such as capacity in the provider market, difficulty navigating the system, the impact of short care visits, or the role social care can play in supporting people to live life.

These case studies are just snapshots and it is likely that the experiences they describe will resonate with the many people accessing services. In 2015/16 there were:

- Just over 1.8 million requests for support from new clients.
- 209,000 completed instances of short-term support to maximise independence for new clients, with over half (54 per cent) receiving such support following discharge from hospital. This is in addition to 36,000 cases of support for existing clients.
- 873,000 clients receiving long-term support, with 652,000 still accessing such support at the end of the year. 482,000 had been accessing this support for more than 12 months.
- 387,000 carers in contact with their council, of whom 314,000 received direct support¹⁰.

The LGA is extremely grateful to the individuals and national partners involved in helping to develop these perspectives.

¹⁰ 'Community care statistics, social services activity, England, 2015/16', NHS Digital, October 2016
www.content.digital.nhs.uk/catalogue/PUB21934

Angela's story

Angela is in her late 60s and has needed life-long care

I get half an hour in the morning, three quarters of an hour for lunch, half an hour in the middle of the afternoon, three quarters of an hour around 5.00pm for tea, and half an hour around bedtime. It's the same every day.

This type of care means I have to think about the consequences of everything I do because I can't afford to miss my care slots: if I miss too many it'll be taken away. It means I can't be spontaneous.

This doesn't give me the freedom to go out when I want or do all the things that matter to me – church activities, concerts, being a patient representative, campaigning. I have almost no social life.

There's no privacy and that really affects me. I can't see my friends like I used to because you can't talk when there's a support worker around – I know they feel awkward and my friends feel awkward too. Friends can't stay over when a support worker is sleeping in the kitchen. I've lost many friendships.

It's like being institutionalised and I'm treated like a kid – “now we're getting up, now you do this, now you do that”. It's an entire reversal of what I believe was my right: to live in the community as an equal. I'm appealing at the moment and I'm just waiting for an assessment. I hope I will get more support.

What would my ideal social care look like? It would be 24/7 with the support workers living upstairs and my individual budget giving me enough money so they can live in the flat comfortably: I have my privacy, they have theirs.

Serious money needs to be put into social care to enable disabled people to aspire to something. Society needs to evolve and there needs to be a lot more in the media about disability issues.

I've got a bucket list of things that I want to do but I'm prevented from doing them because we've reverted to a medical model of disability and not a social model. To me, the social model means that I would have someone 24/7 to enable me to do what I want to do, when I want to do it.

With thanks to Angela and Scope for their help in providing this perspective

It's an entire reversal of what I believe was my right: to live in the community as an equal

Alex's story

Alex was a full time carer for his mother who is living with dementia

I moved into my mother's home before her diagnosis as she was very unwell. Following her diagnosis we were awarded assistance in the form of a carer visit once a day. But because of my mother's condition this only made things worse as she didn't understand who the carers were. She was scared.

I spoke to my council about financial support and was told I would be eligible for carer's allowance. But I was also told this would be deducted from my mother's disability allowance so I declined it.

Looking for a care home for my mother was very difficult emotionally. I wanted her to be in a safe environment that was close to where she lived so that she was familiar with the area. My mother only stayed in the first home for six months because I was told they could no longer care for her. I don't think the staff had the appropriate dementia training to know how to look after her; on one occasion when I visited her I found her laying on the corridor floor crying with carers just walking around, ignoring her.

Looking for a care home for my mother was very difficult emotionally

My mother then spent two years in hospital to ensure she received the right level of care and medication. Staff and the quality of care was very good. Sadly however, there was an incident after the first year when staff got the medication wrong and my mother went into a coma. When she woke up her care needs had increased greatly and finding her a new care home was a near insurmountable task that took the best part of nearly a year.

I visited over fifteen homes and none would accept my mother. I believe this is because the care and nursing homes wanted to pick residents with smaller care needs but who would pay the same price.

Just as I felt like giving up I was contacted by a home that offered my mother a place. Initially, staff were provided through an agency with carers ranging from good to, at times, nasty. Now the home operates in-house staff but I still don't fully trust the care provided because of a long list of incidents which concern me.

Despite these concerns, my experience of the difficulties I encountered finding this home means that I feel that my mother and I are stuck with it. I'd like to report my concerns about the level of care to an organisation but I'm worried that if I do this, or lodge a formal complaint, it will have a detrimental effect on my mother's care.

With thanks to Alex and the Alzheimer's Society for their help in providing this perspective

Geoff's story

Geoff is a carer to his wife Jean, who is living with multiple sclerosis

When my wife, Jean, was diagnosed with MS around 18 years ago, I was the headteacher at a local school in Lancashire. A combination of supportive and understanding colleagues, Lancashire County Council and an increasing and supportive social care package meant I was able to continue working until I retired.

Jean has been tetraplegic for several years and needs significant levels of care including support with feeding and drinking. She received social care support for many years and recently transferred to Continuing Health Care because her needs have increased.

The role of social care in our lives has been vital and transformative. Jean has managed direct payments to be able to organise care assistants to support her. And I have been able to look after my own health and wellbeing. We both volunteer in our local community with charities that support disabled people and carers. When the care assistants are not there, I provide all other care and support which is the majority of the day.

When I was elected Mayor of St Helens in 2012-2013, the social care that we received enabled me to fulfil this role and importantly, enabled Jean to play her full role as the Mayoress; to take a full part in a public role. She has published a book, "The Mayoress with MS" to show what a difference good support can do for someone who has significant disabilities – demonstrating a positive role model for diversity and inclusion in the local community.

When I was ill and needed support after an operation, we had extra care as I could not lift or move Jean. This was vital to my recovery and without it Jean would have had to go into a care home, which neither of us wanted.

It's hard to imagine my life and Jean's if we had not had this support. The care that is provided with the help of care assistants is physically demanding. I would certainly have had to give up work and greater care responsibilities would have impacted on my health and wellbeing as well as on our finances. We would not have been able to support the local community and our relationship would also have been different. The care that we receive gives Jean her own independence and control, which is vital so she doesn't feel she has to rely on me for everything.

Life obviously changed when Jean had the diagnosis and she became more disabled. Life continued to change. People don't choose to be a carer and you don't realise sometimes, even for many years. Without social care both of us would not have been able to lead such full lives. The support that we have had has given us positive and active lives. Whilst things are much more challenging living with MS, we work round things with the help of the care that we get. I can't even imagine what life would be like without the care that we have.

With thanks to Geoff and Carers UK for their help in providing this perspective

The role of social care in our lives has been vital and transformative

Josie's story

Josie was a nurse until 2008 when she developed a number of impairments affecting her health and mobility

At the moment, I get three short visits a day from a care worker to cook my meals, help me shower, and keep the house clean. I get two hours every two weeks "social" time which at best on a good day gets me over to the park and back.

It's not long enough to join in any activities but I value this time hugely as it's uninterrupted time with actual real conversation, not just "what do you need to eat?" or similar.

My basic needs are met – I'm clean and I'm fed. But I haven't got enough support to actually get me out of the house. It means that some days I barely get to speak to anyone, let alone have a social life.

If I get an infection and have to ask my carer to pick up a prescription, I don't get to have a shower that day. There just isn't enough time.

A little more support – for example, a support worker to go with me to new places – would give me so much more opportunity to take part in life, but at the moment that feels like an impossible utopia!

People like me, who were professionals and could make a contribution with the right support, are being cut out of the workforce.

Working in an office or a hospital isn't really possible for me, but I still have skills and experience that I would like to use, if I had the means of doing so.

In the end, it is a question of equality. In a fair world, I would have the support I need to live my life, and the opportunity to fulfil my capabilities.

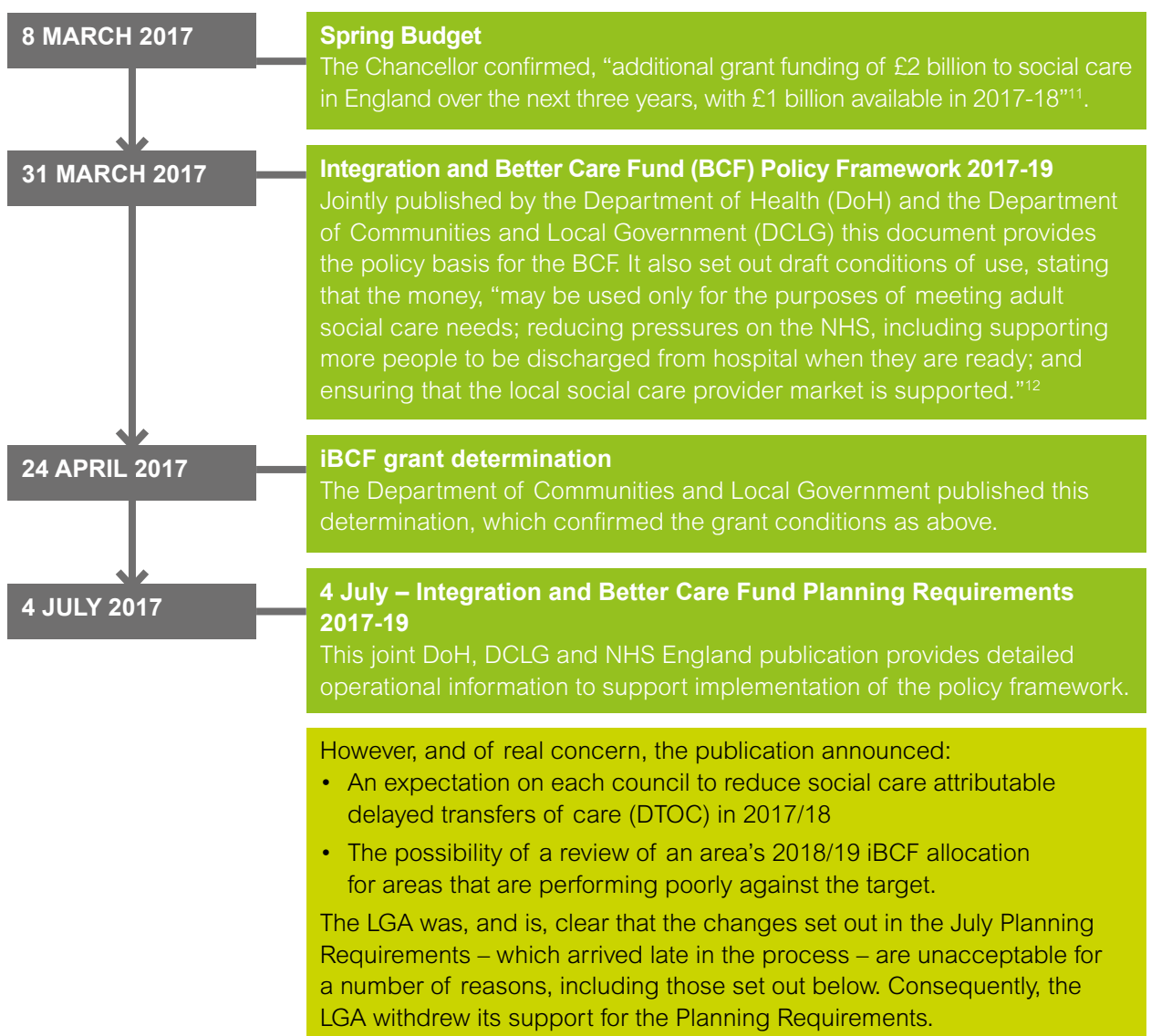
I'd be able to go out and have a social life. I'd have support to do some work, maybe based at home where I would be able to control my surroundings. Instead I don't feel like I'm living, just existing.

Reproduced with the kind permission of Scope

In a fair world, I would have the support I need to live my life, and the opportunity to fulfil my capabilities

The 2017 Spring Budget: what is the £2 billion really for?

The above stories are a powerful reminder of why adult social care matters, what the service achieves at its best, and what the consequences are of continued underfunding. The LGA, along with national partners across the care and support sector, put these arguments forward loudly and frequently in the run up to the 2017 Spring Budget and the Government responded with an additional £2 billion. But as alluded to earlier, recent developments have meant this cannot be seen as a straightforward £2 billion investment going directly to adult social care. To understand why it is worth reflecting on the following chronology:



11 2017 Spring Budget speech, Rt Hon Philip Hammond MP, March 2017
www.gov.uk/government/speeches/spring-budget-2017-philip-hammonds-speech

12 ‘2017 -19 Integration and Better Care Fund Policy Framework, HM Government, March 2017
www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

Uneven grant conditions: The changes give disproportionate dominance to ‘reducing pressures on the NHS’ and within that an extremely narrow focus on DTOC. This was not a feature of the overarching Policy Framework. Furthermore, the Planning Requirements largely ignores the fact that the other two grant conditions (‘meeting adult social care needs’ and ‘ensuring that the local social care provider market is supported’) also directly benefit, and reduce pressure on, the NHS by helping to avoid people being admitted to hospital in the first place.

Target sharing: The NHS England Mandate for 2017/18 sets a target for reducing DTOC nationally to 3.5 per cent of occupied bed days by September 2017. This equates to the NHS and local government working together so that, at a national level, DTOC are no more than 9.4 in every 100,000 adults (ie equivalent to a DTOC rate of 3.5 per cent). This joint achievement would release around 2,500 hospital beds.

This is a joint target, meaning councils are responsible for 50 per cent of the target reduction despite only being directly responsible for 37 per cent of DTOC. Delays attributable to the NHS stand at 56 per cent. The DTOC reduction target also takes no account of the overall volume of NHS discharges to adult social care.

Target setting: The target reduction will be very challenging in many areas. To put it in context, in July 2017 the top four reasons for social care delays totalled 1,951 DTOC bed days. Since February 2017, social care DTOC bed days have reduced by 229. The target reduction set by the Department of Health was approximately 1,250 bed days, leaving a further reduction of 1,000 social care bed days by September. This is equivalent to halving the delayed days due to the four key reasons for social care delays.

Unrealistic expectations: Local areas will clearly use available funding differently in line with local priorities. But for illustrative purposes, the bulk of the much-heralded injection of £1 billion (of the total £2 billion) in 2017/18 could easily be swallowed up by demography, inflation and National Living Wage pressures

totalling £840 million. This pressure is separate to the annually recurring pressure of £1.3 billion to stabilise the provider market. For many areas, this year’s funding only really helps them to stand still at 2016/17 levels. In short, the £1 billion could legitimately be spent several times over on different priorities.

Additional funding in 2017/18: what difference does it really make?

To illustrate this point, consider the adult social care funding position in Nottinghamshire County Council in 2017/18.

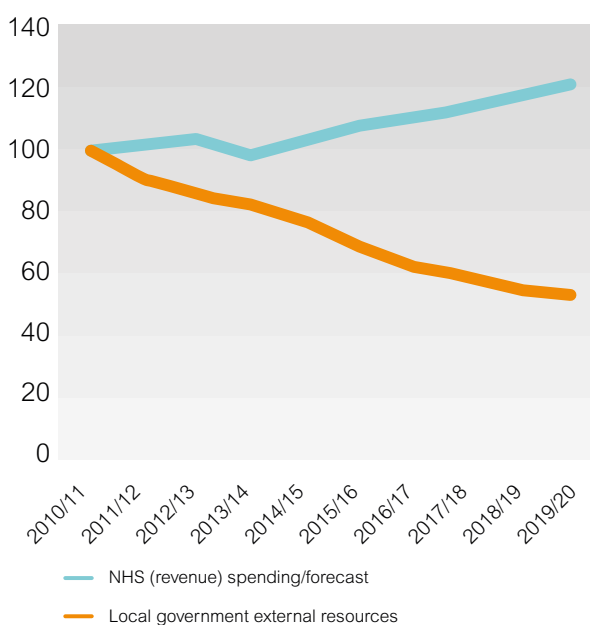
	£000
1) Adult social care (ASC) net expenditure 2016/17	230,929
2) ASC net expenditure 2017/18	233,063
3) Of which precept (@ 3 pc)	9,463
4) Of which iBCF allocation	15,527
5) ASC net expenditure without iBCF allocation	217,536
6) Increase in ASC net expenditure	2,134
7) Pressures reabsorbed/reductions reversed from iBCF	13,393

Councils are responsible for 50 per cent of the target reduction despite only being directly responsible for 37 per cent of delayed transfers of care. Delays attributable to the NHS stand at 56 per cent.

This table demonstrates that the council's iBCF allocation of £15.5 million must not be seen simply as new money. Rather it counteracts what would otherwise have been a £13.4 million fall in the social care budget. The net increase is therefore just over £2.1 million. Expressing this difference in more practical terms is stark: £15.5 million would buy more than 900,000 hours of home care at £17.19 per hour as recommended by the UK Homecare Association. By comparison, £2.1 million would buy just under 125,000 hours. Of course, Nottinghamshire will be using its allocation in a range of ways, but this example clearly shows the inaccuracy and unhelpfulness of thinking about additional funding in isolation from local areas' wider context.

A lack of context: A 50/50 split of responsibility for the DTOC reduction target between councils and the NHS does not reflect the financial position of both sectors. While local government will have managed reductions to its core funding from central government totalling £16 billion between 2010 and 2020, we estimate that NHS spending will have increased by just under £20 billion over the same period, from £95.2 billion in 2010/11 to £114.8 billion in 2019/20.

Figure 6: Percentage changes in NHS spending and core national government funding to local government, 2010/11 – 2019/20



The bulk of the much-heralded injection of £1 billion (of the total £2 billion) in 2017/18 could easily be swallowed up by demography, inflation and National Living Wage pressures totalling £840 million.

Furthermore, while funding for health has continued to increase, providers within the health service continue to report significant deficits. Latest performance information from NHS Improvement¹³ shows that, “The provider sector reported a year-to-date deficit of £736 million for the first quarter of 2017/18, which was £30 million worse than planned.” NHS Improvement reports that most trusts attribute underperformance, “largely to slippage in the delivery of planned efficiency savings, income shortfalls due to lower than planned activity, and continued reliance on bank and agency staff.”¹⁴

Trying to compare approaches to budget management between health and social care is difficult given the operational differences between each side. For example, trusts can set deficit budgets whereas local authorities are required by law to set a balanced budget. But this does demonstrate that councils have had to make tough decisions, innovate, and drive efficiencies far beyond the experience of most people in the health service. We are keen for that learning to be shared.

13 ‘Performance of the NHS provider sector month ended 30 June 2017’, NHS Improvement https://improvement.nhs.uk/uploads/documents/Quarter_1_201718_performance_report.pdf

14 Ibid.

The DTOC debate

A developing blame game

The sudden and late imposition of targets being attached to the £2 billion is a setback in itself. But they also point to a wider malaise of growing central and national direction over health and care funding for local areas coupled with finger pointing at councils. This only serves to undermine local partnerships and local integration.

DTOC have gained greater profile in recent years as a series of difficult winters have compounded rising demand pressures on the NHS and impacted negatively on its performance. In turn, there is now a growing emphasis on local government's role – and the use of its funding – in helping to mitigate NHS pressures.

“Regulators have warned that urgent action is needed to ensure enough hospital beds are available over winter, saying that the Government’s extra investment in social care failed to reduce the number of delayed discharges”

Health Services Journal, September 2017

“Reduce bed-blocking or face cuts, councils told”

The Times, August 2017

“We know that there is a great deal of work to be done over the next six to eight weeks with our partners in local authorities to put the NHS on the right footing for the winter ahead”

Simon Stevens, quoted in *The Independent*,
September 2017

“The Government will take stock of [council] progress in November and consider reviewing 2018/19 allocations of the social care funding provided in the Spring Budget 2017 for any areas that remain poorly performing”

NHS England and NHS Improvement letter to local A&E
Delivery Board Chairs, July 2017

These headlines portray that the prevailing NHS view is that DTOC performance is down to councils, they have the money to turn things around, and a failure to improve will result in punitive measures. And it is a message that will be partly driven by the perceptions of NHS trusts. 'Winter Warning: managing risk in health and care this winter'¹⁵, a recent report by NHS Providers, showed that:

- "Only 34 per cent of trusts report that their local authorities are giving high priority to supporting the NHS reduce DTOC as opposed to meeting other/wider adult social care needs or stabilising their social care market."
- "While 28 per cent of all trusts have received a specific commitment that the extra social care money [the £1 billion in 2017/18] will be used to reduce delayed NHS transfers of care, 59 per cent of trusts have not been able to secure such a commitment."
- "Only 18 per cent of NHS trusts are confident that the commitments they have received will help them meet the NHS England Mandate requirement to reduce DTOC levels to 3.5 per cent."

The DTOC debate: reality check

The LGA is of the clear view that messages and perceptions such as those outlined above are inaccurate, unfair and ultimately unhelpful in addressing system-wide pressures.

As a matter of principle, councils are, and always have been, committed to reducing DTOC and continue to work closely with local health and care provider partners to get people out of hospital and back into the community. Any suggestion, implied or otherwise, that councils do not take this responsibility seriously is deeply unhelpful and damaging to local relationships.

Those relationships matter. Outstanding

¹⁵ 'Winter Warning: managing risk in health and care this winter', NHS Providers, June 2017
<http://nhsproviders.org/media/3215/winter-warning.pdf>

practice (which typically means best performance) is found in areas that have truly joined up systems and model a 'no blame' culture from the top down. For these areas there is no distinction between health attributable delays and social care attributable delays, rather the focus is aimed squarely on quality, person-centred care. This reinforces the idea that central target setting that focuses on one part of the system, and defies best practice on the ground, creates further division in local systems; this is counterproductive, particularly for areas that are struggling.

Councils' principled commitment to reducing DTOC is backed up by early analysis of councils' initial plans for the iBCF, which shows that a significant number of planned schemes will focus on hospital discharge and reducing the length of delayed transfers. Planned activity also includes work on prevention (to keep people out of hospital), and reablement (to ensure people do not return to hospital).

Councils are reducing DTOCs

- ✓ The ADASS budget survey demonstrates that nearly a third (32.3 per cent) of the iBCF funding in 2017/18 is being directed towards the grant purpose of "reducing pressure on the NHS, including supporting more people to be discharged from hospital when they are ready".¹⁶
- ✓ Delays attributable to social care reduced by 9 per cent between February and July 2017.

¹⁶ See 1

So how is this improvement being achieved? The following examples set out in a little more detail how the iBCF is being used in a number of areas. Every single case study area has faced a significant reduction in its spending power¹⁷ since the start of the decade, and the proportion of that spending power spent on adult social care has increased in every area. Every area included below has also used the full social care precept flexibility; 2 per cent in 2016/17 and 3 per cent in 2017/18.

The case studies are a positive demonstration of councils' commitment to working with health partners to reduce delayed transfers and a clear rebuttal to the erroneous messaging and perceptions highlighted above. They show that councils are doing the right things in the face of competing pressures and priorities.

Although councils are responsible for less than half of the delays, they have been tasked with delivering 50 per cent of the target reduction, despite their lower resource base and the substantial budget reductions of recent years.

Nearly a third (32.3 per cent) of the iBCF funding in 2017/18 is being directed towards the grant purpose of “reducing pressure on the NHS, including supporting more people to be discharged from hospital when they are ready”.

¹⁷ 'Spending power' is a Government measure of the amount of funding a council has from core government funding, retained business rates and council tax.

Luton Borough Council

Setting the scene...

Between 2010 and 2017, Luton has faced a 25.32 per cent reduction in its spending power. Social care as a percentage of spending power has increased from 27.67 per cent in 2010/11 to 42.87 per cent in 2017/18.

In July 2017, Luton had one of the lowest rates of delays overall (146th out of 151), and for delays due to the NHS (143rd) and social care (149th). On all counts, Luton's rate of delays is lower than the overall rate for England.

Overall, in July 2017 Luton's rate of delays was 3.6 DTOC beds per 100,000, including 2.3 (63 per cent) due to the NHS, 1.3 (37 per cent) due to both the NHS and social care combined, and no delayed days due to social care alone. This is equivalent to 5.8 (3.6 NHS, 0.0 Social Care, 2.1 both) delayed beds per day.

In February 2017, Luton reported 5.8 DTOC beds. Overall there has been no change in DTOC bed days, however there has been some fluctuation when looking at the delays by the organisation responsible. DTOC beds reduced for NHS (1.4 days) and for social care (0.8 days), but increased for those jointly attributable (increase of 2.1 days).

This health and wellbeing board (HWB) area has some of the lowest DTOC rates in the country, for both social care and NHS. The council has invested the iBCF funding in transformational projects across health and social care to ensure there are appropriate services that help maintain independence, prevent hospital admissions and facilitate hospital discharge.

Working closely with partners in the Clinical Commissioning Group (CCG) and the Housing and Customer Services departments, it is remodelling existing services with a focus on prevention and wellbeing to address its local challenge – that, although discharge figures remain good, hospital admissions continue to rise. Funding is being channelled into enhancing the care home model to develop digital options to help avoid hospital admissions from this client group.

One scheme involves further developing an initial assessment hub at the hospital. Another the broadening of the Hospital at Home service via a provider alliance to help reduce hospital admissions. Partners intend to integrate early supported discharge with the intermediate care and rehabilitation service, streamlining therapy services to deliver a cohesive discharge support service.

The council is also developing early support services to work restoratively and co-productively at the access points to adult social care in order to avoid dependency. This includes developing further local area networks, additional investment in a range of equipment and technology related initiatives, along with a number of self-care and self-management programmes that support individual independence in the community. Supporting this is greater system integration through digital services, communications and business intelligence to enable a cohesive approach across partner agencies to deliver better outcomes at an earlier stage.

Partners intend to integrate early supported discharge with the intermediate care and rehabilitation service, streamlining therapy services to deliver a cohesive discharge support service.

Wigan Council

Setting the scene...

Between 2010 and 2017, Wigan has faced a 29.4 per cent reduction in its spending power. Social care as a percentage of spending power has increased from 27.06 per cent in 2010/11 to 35.89 per cent in 2017/18.

In July 2017, based on overall rates of DTOCs Wigan was amongst the third of councils with the lowest rate (124th), and amongst the 20 with the lowest rates of NHS delays (131st). Based on delays attributable to social care, relative to other local authorities it has the 95th highest rate. On all counts, Wigan's rate of delays is lower than the overall rate for England.

Overall, in July 2017 Wigan's rate of delays was 6.2 DTOC beds per 100,000, including 3.2 (52 per cent) due to the NHS and 2.5 (41 per cent) due to social care. This is equivalent to 15.8 (8.2 NHS, 6.5 social care, 1.2 both) delayed beds per day.

In February 2017 Wigan reported 19.9 DTOC beds. This shows a reduction of around four beds per day which, based on a notional cost of £306 per delayed bed day, amounts to just over £1,200 savings per day. This included a reduction in social care DTOC beds (six per day) alongside an increase in NHS DTOC beds (two per day).

In the top quartile for DTOC performance, this council has used the iBCF funding to sustain some one-off investments and accelerate transformation, which will result in improved outcomes for citizens and avoiding future care costs by delaying the need for some citizens to require formal care services. The investment is accelerating Wigan's whole place approach to asset based working based on 'The Wigan Deal'.

Funding has been used to support the local residential and nursing sector, including large-scale workforce reform and development, and targeting providers' capacity, innovation and quality improvement to reduce A&E visits, improve discharge and support provider sustainability.

The iBCF is also being used to improve the quality and sustainability of community based support, including ethical home care and supported living. In addition, the council is investing in the use of technology to improve the customer experience and system resilience. Another project is enhancing the property adaptations service to support timely discharge, and a new initiative to build mental health capacity to enable people to be supported in the community.

This council has used the iBCF funding to sustain some one-off investments and accelerate transformation, which will result in improved outcomes for citizens and avoiding future care costs by delaying the need for some citizens to require formal care services.

Nottinghamshire County Council

Setting the scene...

Between 2010 and 2017, Nottinghamshire has faced a 20.51 per cent reduction in its spending power. Social care as a percentage of spending power has increased from 40.95 per cent in 2010/11 to 47.27 per cent in 2017/18.

In July 2017, based on overall rates of DTOCs Nottinghamshire was amongst the third of councils with the lowest rate (101st), and amongst the twenty with the lowest rates of social care delays (132nd). It is however amongst the third of council areas with the highest rates of NHS delays (46th).

Overall, in July 2017 Nottinghamshire's rate of delays was 8.6 DTOC beds per 100,000, including 7.7 (90 per cent) due to the NHS and 0.6 (7 per cent) due to social care. This is equivalent to 55.5 (50.1 NHS, 4.1 social care, 1.3 both) delayed beds per day.

In February 2017 Nottinghamshire reported 59 DTOC beds. This shows a reduction of just less than four delayed beds per day which, based on a notional cost of £306 per delayed bed day, amounts to just over £1,000 savings per day.

This large county, which has good performance, is using the iBCF funding to support transformation of adult social care services. This seeks to manage demand and cost by promoting independence and wellbeing, ensuring value for money, and promoting choice and control. It is intended to protect support for people with the highest long term needs and lowest incomes, while encouraging other people to be more independent through offering alternatives to social care support or short term support to enable a return to independence.

The county has already invested in the social care provider sector at a time of significant national funding reductions, but this is not enough to ensure adequacy and supply in the local social care market, especially in relation to the growing requirement of speed of access and level of complexity of needs that requires addressing to support hospital avoidance and swift discharge.

As a result, some of the funding is being used to increase fees to cover national living wage and inflation increases. Some of it is supporting increased social care reablement to support hospital avoidance/discharge and enable independent living. This includes a faster response to meet more complex needs required to implement Home First, Discharge to Assess and seven day working. Additional social care assessor posts in the hospital integrated discharge services will boost capacity and support good DTOC performance.

The council is also using some of the funding to retain some preventative services such as community based 'Connect' services, commissioned from community and voluntary sector organisations, offering short term support to older people and to prevent or delay deterioration or escalation of need. In addition, the council is investing in care and support services for adults with multiple and complex needs arising from learning disabilities, autism spectrum disorders and/or mental health need, to meet the rising demand in younger adults' services.

The council is also using some of the funding to retain some preventative services which were reduced in previous years because of savings requirements.

Staffordshire County Council

Setting the scene...

Between 2010 and 2017, Staffordshire County Council has faced an 18.4 per cent reduction in its spending power. Social care as a percentage of spending power has increased from 39.82 per cent in 2010/11 to 46.88 per cent in 2017/18.

In July 2017, Staffordshire had the 28th highest rate of delays overall, and the 19th highest due to social care alone. 51 per cent of delayed days in Staffordshire in July 2017 were attributable to social care, 46 per cent to the NHS and the remaining 3 per cent to both NHS and social care combined.

Compared to the rate of delays for England as a whole, for July 2017 Staffordshire's rate of NHS delays is the same as the all England figure of 7.5 DTOC beds per 100,000 aged 18 and over. The rate of delays due to social care is higher than the all England rate at 8.4 DTOC beds per 100,000 aged 18 and over, and overall 16.3 DTOC beds per 100,000 adults. This is equivalent to 114 (52.6 NHS, 58.3 social care, and 3.1 combined) delayed beds per day. In February 2017, Staffordshire reported 136 (60.3 NHS, 70.4 Social care and 5.4 both) delayed beds per day, showing a balanced picture of reduction across all attributable organisations, and similarly all reasons for delay.

Staffordshire County Council and NHS partners are significantly reducing high rates of unplanned hospital admissions and delayed transfers of care through a scheme called Integrated Prevention and Discharge to Assess.

It is designed for people who do not need to be admitted to hospital when they present at A&E therefore avoiding admission in the first place, or are medically fit to leave hospital and who can benefit from reablement and/or are unable to look after themselves.

Instead of waiting on hospital wards to be assessed by a number of health or social care professionals, people either go home or to a bed based service; here they receive up to six weeks of intensive support to aid their recovery and regain full independence wherever possible. Any long term care needs are also assessed at this stage and put in place for when they are discharged at the end of the six week period.

The scheme is in operation in the North of Staffordshire at the Royal Stoke Hospital and has reduced social care delayed transfers of care for North Staffordshire residents to almost zero. The scheme has been identified as a national model of best practice with requests made by council and NHS organisations in other areas to visit Royal Stoke and see it in action.

The Staffordshire BCF plans to continue this work and invest in additional capacity to roll the scheme out to other hospitals in the county. This would enable more people to avoid a hospital admission and to return home quickly after hospital discharge, offer them a better experience and easing pressure on the county's hospitals.

Cllr Philip Atkins OBE, Leader of Staffordshire County Council says:

"Everyone recognises the importance of ensuring that people leave hospital as soon as it is safe for them to do so. In the North of Staffordshire, through good practice, we have managed to reduce social care delays for people leaving hospital to practically zero.

"Staffordshire County Council wants to replicate this across the whole county, but this takes time, so we have submitted a BCF plan agreed with Staffordshire CCGs to achieve the targets by August 2018. This approach is both achievable and sustainable.

“The sudden introduction of targets in July this year, which are impossible to meet, and consequent withholding of social care funding would mean we are unable to provide care for very vulnerable people and will make hospital discharge delays much worse.

“If the funding is not honoured, the services it funds will have to be reduced. This will leave the most vulnerable people without care and will drastically increase pressure on the NHS leading to more hospital admissions and slower discharges, just as winter is approaching.

“More broadly this is damaging the relationships we need to develop a sustainable future for health and care services in Staffordshire.”

The sudden introduction of targets in July this year, which are impossible to meet, and consequent withholding of social care funding would mean we are unable to provide care for very vulnerable people and will make hospital discharge delays much worse.

Sheffield City Council

Setting the scene...

Between 2010 and 2017, Sheffield has faced a 33.06 per cent reduction in its spending power. Social care as a percentage of spending power has increased from 25.58 per cent in 2010/11 to 39.52 per cent in 2017/18.

In July 2017, Sheffield was amongst the 20 authorities with the highest rate of DTOCs overall (16th) and for NHS delays (19th). Relative to other local authorities they had the 33rd highest rate of DTOCs attributable to social care. Overall, in July 2017 Sheffield's rate of delays was 19.7 DTOC beds per 100,000, including 11.7 (59 per cent) due to the NHS and 6.5 (33 per cent) due to social care. This is equivalent to 90.3 (53.6 NHS, 29.9 Social Care, 6.8 both) delayed beds per day. In February 2017 Sheffield reported 170.9 DTOC beds.

This shows a reduction of around 81 beds per day (41 due to NHS, six due to social care, and 34 due to both) which, based on a notional cost of £306 per delayed bed day, amounts to almost £25,000 savings per day.

Sheffield City Council, like other councils across the country, finds itself under a lot of scrutiny both regionally and nationally because of its DTOC performance. The council's response has been multifaceted, addressing both soft and hard issues within the system. As a starting point, work is being done to improve relationships across health and social care. This is seen as the essential foundation for improvement and there are encouraging signs it is already having an impact.

The council's share of the additional £1 billion for social care in 2017/18 is partly being used to establish an 'innovation fund' to directly support the rapid development of different schemes to reduce both delayed transfers from hospital, and the use of care homes following hospital discharge.

The funding is also being used to optimise the council's reablement service, the short and intensive support to help build people's confidence and skills in living independently at home, particularly following time spent in hospital. By investing some of the money in this way, Sheffield is improving its capacity to respond to patient flow and help people avoid admission to hospital in the first place, or readmission.

More generally, Sheffield is taking steps to manage its processes and resources more effectively, invest in its workforce and stabilise the provider market. Such focus helps the council tackle the general increase in demand for services it faces due to demographic change locally. Sheffield is making good progress on this front, having redesigned its 'front door' to improve its offer to citizens and its effectiveness. This includes better information and advice and earlier decision making by management, which helps to build a more streamlined flow of requests for services. In turn, this helps provide a more accurate picture of demand and a more resilient set of structures to respond to that demand. Investment in the social care workforce – social work and community support – and the systems they use is central to this.

Stabilising the home care provider market is another priority. Prior to the iBCF funding, Sheffield had increased its home care fees by 8 per cent and set up a new commissioning framework. These were positive developments but there was more to do to support improvements in quality, capacity and relationships.

The council has therefore earmarked part of the iBCF investment to further increase fees for home care providers, but on the proviso that this will directly improve terms and conditions for staff in the hope that staff retention can be stabilised during peak winter periods.

As the council says, "Additional investment in adult social care is used to enable a sustainable shift in the council's approach that improve outcomes for local people". It is clear from the range of activity planned and underway, that these improvements span both health and care, relieving pressures on both sides of the system.

Sheffield is improving its capacity to respond to patient flow and help people avoid admission to hospital in the first place, or readmission.

Hertfordshire County Council

Setting the scene...

Between 2010 and 2017, Hertfordshire has faced a 16.76 per cent reduction in its spending power. Social care as a percentage of spending power has increased from 36.69 per cent in 2010/11 to 47.57 per cent in 2017/18.

In July 2017, Hertfordshire had the 31st highest rate of DTOCs overall, 23rd highest for NHS delays, and 53rd highest due to social care. Overall, in July 2017 Hertfordshire's rate of delays was 16.0 DTOC beds per 100,000, including 11.0 (69 per cent) due to the NHS and 4.8 (30 per cent) due to social care. This is equivalent to 145.8 (100.0 NHS, 44.0 social care, 1.9 both) delayed beds per day.

In February 2017 Hertfordshire reported 202 DTOC beds. This shows a reduction of around 56 beds per day (36 due to NHS and 20 due to social care) which, based on a notional cost of £306 per delayed bed day, amounts to just over £17,000 savings per day.

Hertfordshire County Council was allocated just over £13 million in 2017/18 from the iBCF, dropping to just over £11.6 million in 2018/19 and £5.8 million in 2019/20.

In the first year, the council has prioritised funding home care packages, in part to offset reductions in CCG funding to adult social care. However, over a third of the iBCF money is being spent on new schemes to reduce pressure on the NHS. Short-term care and reablement in people's homes, or using 'step-down' beds or 'reablement flats' to bridge the gap between hospital and home, ensures that people do not remain in hospital unnecessarily waiting for assessments.

The council has also invested in the workforce, using some of the funding to increase hourly wage rates for homecare workers, with the intention of bolstering recruitment and retention in this low paid sector of the market. This is in part because it is difficult to attract new workers into homecare because other parts of economy can offer more favourable terms and conditions. Additional funding has also been earmarked for training schemes to upskill care workers so they are better equipped to deal with the more complex cases they face, so enabling them to better handle crises in people's homes without having to call an ambulance, avoiding inappropriate admissions.

The remaining funding for this year is being used to create capacity in social work and occupational therapy and to develop the offer from the voluntary sector into the NHS. The latter will create a county-wide Integrated Home Discharge and Community Navigator service, which facilitates discharge from hospital, links people to support in the community, helping to reduce the need for statutory services and prevent escalation to crisis point and the need for hospital admission.

Hertfordshire County Council acted quickly to begin spending the iBCF money. By mid-April the council had agreed a plan with local NHS Partners for iBCF monies and used its executive powers to begin spending it. Commissioning began in April with some schemes operational in May.

The county, which has often seen higher numbers of delayed discharges, has been set a reduction target of 63 per cent for social care delays. Assistant Director for Health Integration, Jamie Sutterby was recently interviewed in an article about new DTOC targets from NHS England. This is "extremely challenging", Jamie says. "Whether it's realistic, in such a short time frame, remains to be seen."

We know that prolonged stays in hospital are never in a patient's best interests; our priority is always to get people discharged as soon as they are well enough."

There are no obvious or short term solutions to rising delays. "Nationally, market fragility is underpinning the DTOC situation from a social care point of view," Jamie says. "If you don't have the ability to generate capacity, it's hard to think about how to move beyond the immediate situation. Simply, investment hasn't kept pace with the demand being placed upon care."

Director of Adult Care Services in Hertfordshire, Iain MacBeath, said "Keeping morale up in hospital teams who are seeing a 50 per cent plus rise in referrals over the past year, the highest number of complex discharges ever achieved in August 2017 but a stubborn number of delayed discharges is difficult. We all know that DTOCs are a symptom of wider system issues. I'll be ensuring that I'm working with our system partners to also monitor the wider causes and act on them. And we'll celebrate the positives – social care delays in Hertfordshire have reduced every month since the iBCF began."

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Providing positive solutions

Local government's first priority is to release and spend money on vital services to support the many thousands of people who will depend on our health and care services over the coming winter months. The LGA is therefore urging Government and NHS England to change its approach by:

Demonstrating greater recognition of:

- the context adult social care is operating in and the challenges facing the system, including rising costs and the costs associated with supporting working age adults, not just older people
- councils' efforts to date and the improvements those efforts have yielded; the value and core purpose of adult social care in helping people to live independently and supporting their wellbeing.

Being more pragmatic and approving BCF plans that:

- cannot realistically achieve the Government DTOC target but nonetheless contain a credible and stretching target that is backed up with a credible strategy; or
- have a credible strategy for meeting the DTOC target, but not by the November deadline.

Working:

- collaboratively and building stronger links between the LGA and regional NHS England leads to better coordinate support and action on DTOC
- with all parts of the sector to identify and disseminate best practice.
- towards improvement in a way that supports local areas, rather than penalises them.

To avert a deepening of the crisis facing adult social care the Government must act to close the £2.3 billion funding gap facing the service by the end of the decade. This means adequate funding to address the immediate pressures outlined earlier in this report, particularly those facing the provider market. As part of this, the additional funding for adult social care announced in the Spring Budget should be put into councils' baselines so it can be counted on in future years – either through business rates retention or grant funding. Without action, the concerns of those individuals who have shared their experiences of care and support in this report will only increase.

For those individuals, their peers, and for the longer-term sustainability of the service, the Government must also bring forward its planned consultation on proposals for reform as a matter of urgency. Local government must be a key partner in the Government's development of these proposals and cross-party consensus must be sought in the national interest.

The content of this report reinforces the idea that the future of adult social care is inextricably linked to the fortunes of our NHS. Therefore it is essential that, in dealing with the pressures facing social care and health in the short and long-term, the Government develops a balanced approach that does not give one part of the system primacy over the other. This requires recognition of social care as a vital service in its own right for adults of all ages, not simply a causal factor in the performance of the NHS.

Where do we go next?

Indeed, the context that adult social care is operating in that this report has set out could well be expanded to consider the wider NHS context. Here for instance, emergency admissions, A&E attendances, four to twelve hour A&E admission waits, district nursing capacity, and out of hospital investment are all moving in the wrong direction. This adds further weight to the idea that, by seeking to address pressures where they present, rather than tackling problems at source, efforts to improve health and care are focusing on the wrong part of the system.

The narrow focus on DTOC is a clear case in point and is creating a short-sighted emphasis on the consequences for the NHS of what social care does or does not do. This approach fails to recognise – at least with any real balance – that what the NHS does or does not do can have just as an important impact on adult social care. Pressures on, and reduced investment in, things like incontinence treatment, stroke rehabilitation, NHS Continuing Care, district nurses and other out of hospital investment all represent ‘cost shunts’ that increase pressure on adult social care. Furthermore, the pressure to free up hospital beds means that people are being discharged with more serious social care needs who then have more need for care services, which in turn places even greater pressure on adult social care.

As the LGA has consistently argued, considerably more focus should be given to stopping people having to present at hospital in the first place. Therefore, an effective response to tackling DTOC – as with any system-wide issue – must consider the whole system.

Without investment in primary, community and social care services the vicious circle will continue in which we seek to treat the symptoms rather than the causes of system pressures. As Richard Humphries from the King’s Fund has argued:

“It is clear that places with higher delays for social care reasons are much more likely to also have higher delays for NHS reasons. This implies that there are issues within the local health and social care economy as a whole that drive the level of delays and so the focus ought to be on the performance of the system rather than individual organisations within it.”¹⁸

Refocusing our response to the pressures facing our care and health system has implications for the future direction of integration more broadly. Local government remains committed to the integration of health and care in the interests of ensuring joined-up services that achieve the best outcomes for individuals requiring services. But without question, the Government’s main vehicle for driving integration forward operationally – the BCF – has lost credibility. Far from giving practical manifestation to the ambition of integration, the BCF has only served to recast that ambition in increasingly narrow terms.

¹⁸ ‘Delayed discharges: it’s not just about the money’, King’s Fund, February 2017
www.kingsfund.org.uk/blog/2017/01/delayed-discharge-not-just-about-money

We need a clear, consistent vision for our health and care systems which enables proper integration based on agreed local plans, accountable to HWBs and local leadership. In the long term the NHS itself will only succeed if it is locally accountable and can operate effectively as part of a whole system of health and care, taking account of the role of prevention and public health. We therefore need a new approach that moves beyond the BCF and allows local areas to agree long-term plans for integration, with funding for social care going directly to councils.

These proposals are significant and require bold action to see them through. But we are now at the point where tinkering at the edges of our care and health system will bring no benefit. In the interest of all individuals requiring services, their families, friends and carers, and the wider system that supports them, it is time for the Government to act.





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REF 1.69