The Impact of the Comprehensive Spending Review and Recent Local Government Settlement on Adult Social Care in London

A briefing for the Red Lines Campaign Steering Group
January 2016

Foreword by Heidi Alexander MP, Labour's Shadow Health Secretary

In the short time I have been Shadow Health Secretary, it has become clear to me that our health and care service is facing unprecedented challenges.

Hospitals are facing huge deficits, there is a crisis in A&E and staff morale is at rock bottom. These are the issues that you read about in the newspaper, the issues that are subject to public petitions and the issues that people take to the streets in protest about.

They are the campaigns with a voice – and they deserve to be heard. But, at the same time, there is a silent community who have little voice, who have been suffering alone for too long and who have been abandoned and forgotten by this Conservative Government.

Cuts to adult social care aren't like cuts to library services – open and public for all to see. They happen behind closed doors. They happen to people without the means to pay for care themselves. To people too proud to complain or too frail to act. They remain hidden from public view unless they are happening to you or to a close family member. And yet, these cuts are deeply damaging to our communities and to the sustainability of our NHS.

The analysis presented in this paper is further evidence that the Government's plan for funding elderly care is woefully inadequate and the current settlement for social care is not sustainable – for London or for the country. Ministers might be in denial, but the sad truth is that the gradual dismantling of social care services over the past five years has left the NHS bleeding.

Increasing numbers of frail, elderly people are reaching crisis point, ending up in A&E and then getting stuck in hospital. The image of men and women in their 80s or 90s, left alone in beds in emergency admissions units or in rehabilitation wards is the uncomfortable truth that stays with me after months of visiting hospitals up and down the country. It's an experience which left me asking "is this the best place for them and is this the best our health system can do?"

Going to hospital will sometimes be necessary for us when we are old, but it should not become the norm. When Aneurin Bevan founded the NHS in 1948, he said: "Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised." That principle was right for healthcare in the 20th century and it is right for elderly care in the 21st century. Growing old is not a misfortune, it's a privilege and we should not punish people because of it.

We need a fundamental redesign of elderly care services in this country so people get the support they need, when they need it. For too long politicians have failed to grasp the nettle. But how we fund and reform elderly care is the challenge for our generation – and we will only overcome it if we have Labour councils, a Labour London Mayor and a Labour government in 2020. If we fail to act today, then thousands more people will be left suffering in silence and without a voice. I'm determined not to let that happen – and so is the Labour Party.

Overview

This briefing reviews the trends in adult social care spending across London from 2009-10 to 2019-20. Over this decade, substantial year-on-year cuts to local government have been - or will be - experienced by London borough councils. Although adult social care expenditures have been largely protected for the first five years, rising demand coupled with rising costs of care have created a funding gap. Additional planned spending cuts from 2016 to 2020 raise doubts about the sustainability of the current funding model for social care.

The recent Comprehensive Spending Review proposed bridging the social care funding gap with a a 2% "precept", i.e., an increase in council tax reserved for adult social care expenditure. The impact of this precept is estimated. The London effects of additional Better Care Fund monies are noted. The inter-relationship between adult social care and the NHS is reviewed, including what the literature suggests about how the gap in social care spending affects NHS services. Beyond the facts and figures, we describe how the squeeze on adult social care has affected services users, and we suggest what projected cuts - or limited access - might portend for the future.

The discussion questions were posed by the Red Lines Campaign. Sources of data and relevant literature are cited in footnotes and endnotes.

Key discussion points:

The local government settlement for London's councils means core funding will be 30% less in 2019-20 (a 34% decline in real terms from 2015-16). This puts extreme pressure on local authorities to meet their obligations for adult social care provision. How these cuts will affect local tax and spending decisions is not yet clear.

Our research shows that, as a result of government cuts and demographic changes, by 2020 there will be a cumulative £1.7b hole in adult social care funding across London. If every London council were to levy the government's new 2% precept and optimise Better Care Fund income and local tax receipts, the gap shrinks by £980m but still leaves a gap of £754m.

There is growing evidence of unmet needs in the adult social care population. Since 2009-10, nearly 20% fewer people have been receiving support. Demand for adult social care is increasing through population growth, estimated at 5.3% for adults 18-64 and 9.6% for adults 65+ in the next five years. Following cuts in social care funding since 2009-10, publicly funded care has increasingly been targeted at those with the most complex needs, leaving many receiving services insufficient for their needs.

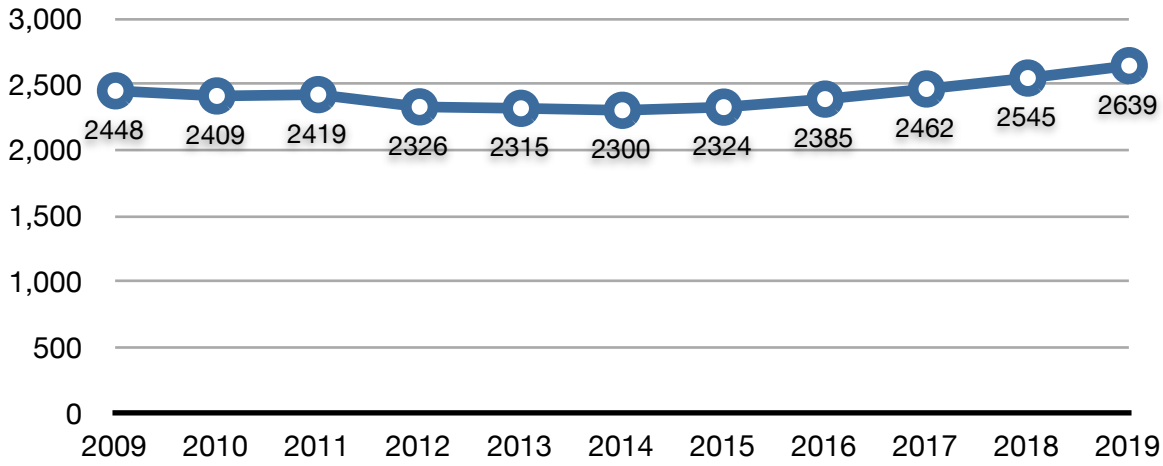
Evidence supports the conclusion that social care cuts are delaying hospital discharges and adding to the pressures across the health system, from primary care to hospitals. The direct impact of social care cuts on NHS finances cannot be estimated without more research.

1. "How much do London's councils together spend on adult social care (ASC) each year, and roughly how many elderly or vulnerable people receive support?"

London borough councils will spend an estimated £2.32 billion on adult social care in 2015-16. This represents around 16.4% of total council spending, although the proportion varies by borough. Nine councils currently spend one out of every five pounds (or more) on adult social care. By 2019-20, it is estimated that £2.64 billion will be spent on adult social care in London.

The trend in adult social care gross expenditures is shown in Figure 1. Between 2010-11 and 2014-15, London councils reduced their spending but largely protected social care budgets whilst facing 44% real terms cuts to core services. The reduction in expenditure was far less for social care than for other council services. For 2015-16 and beyond, expenditure figures are estimated, based on population growth assumptions and London council projections; actual planned expenditure may be less than these figures.

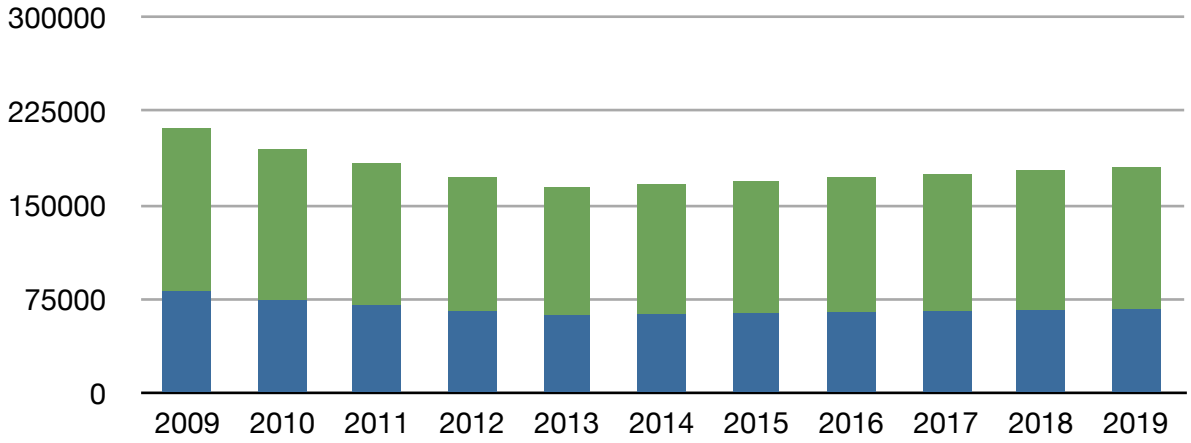
Figure 1: London Adult Social Care Gross Expenditures (£m)



Note: Gross expenditures are estimated for 2015-16 through 2019-20.
Sources: Health and Social Care Information Centre for 2009-14; London Councils estimates for 2015-20.

Figure 2 below illustrates that the number of people who received services declined by over 20% between 2009-10 and 2013-14, from over 211,000 people to 164,000. From 2014-15, numbers have risen slightly to 166,603, but it is estimated that the total number of service users in 2019-20 (180,316) will still be about 15% lower than the number of service users in 2019-10.

Figure 2: Numbers of Users of Adult Social Care by Age Group



Sources: Health and Social Care Information Centre for 2009-14; London Councils estimates for 2015-20.

2. "How much is demand for ASC in London expected to increase in the next four years to 2019/20, i.e., how many more people will need support, and at how much extra cost?"

Demand for adult social care in London is affected by changing demographics, both rising numbers of London residents and changes in demographic composition. Demand estimates are also affected by prevalence rates for disabilities and co-morbidities. It is difficult to predict estimated costs of unmet need without making assumptions about the volume of services, places of care, service costs, price inflation (including the National Minimum Wage, NI and pension costs) and the total value of care, including self-funding and informal caregiving.

Estimating unmet need is also tricky. Figure 2 above shows a steep decline in real numbers of service users by 20% since 2019-10, at the same time we know that demand has increased from population growth alone. We also know that compared to other English regions, within London there are proportionally higher levels of mental health diagnoses; higher levels of adults registered blind or partially sighted; more adults receiving meals or receiving social care support throughout the year; and more older people receiving attendance allowance. By 2019/20, London is expected to have a higher percentage share of growth amongst these groups and will therefore face higher a higher growth in funding pressures.

Unmet demand can also be defined as partial support. The National Audit Office has reported that around three-quarters of the recent reduction in local authorities' spending has been through reducing the amount of care provided. The fall in service volumes was accompanied by reduced unit costs, and this combination led to reduction in spending.[1] This effect was observed in London, with the average spend per user declining over the same period. Other studies have noted the increasing reliance on unpaid carers as local authority spending has diminished.[2]

So, what is the gap? Can we put a figure on the number of people requiring care but not receiving public support? And can we then estimate the additional costs? For the sake of this analysis, we will use the recognised figures from London Councils. The expenditure data in Figure 1 take 2015-16 user numbers as a baseline for projections of demand, with social care population growth calculated at 1.5% per year, assuming 5.3% over five years for adults 18-64 and 9.8% for adults 65+.[3] Inflation is also factored into the calculations. The estimated expenditures for 2016-17 to 2019-20 therefore include the growth in both demand and inflation costs.

Table 1: Estimating the social care funding gap, by projecting expenditures and numbers of users based on 2015-16 baseline data

	2016-17	2017-18	2018-19	2019-20
Projected expenditures (£m)	2,385	2,462	2,545	2,639
Number of service users	171,891	174,650	177,458	180,316
Estimated funding for adult social care	2,262	2,126.5	2,013	1,895
Estimated social care funding gap	123	335.5	532	744

Source: London Councils, using PSSEX from Health and Social Care Information Centre, 2015

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[1] National Audit Office, "Adult social care in England: Overview", March 2014.

[2] John Appleby, Data Briefing: "UK's health and social care spending plans: more of the same?", BMJ, 2015;351:h6458.

[3] Estimated population growth is based on the following assumptions: 18-24 = 5.3% between 2015 and 2020; 65+ = 9.6% between 2015 and 2020. Together, this averages approx. 1.45% per year. Source: London councils.

One could argue that the projected expenditures underestimate the true demand for care because they exclude people not eligible for care or whose care is sub-optimal, such that their care needs are not fully met. We cannot make useful judgements about this type of unmet need for our calculations because the data are not available. Previously, London Councils estimated that the social care funding gap would be £700m per annum by 2020, and this number still holds.[4] We will now test how the settlement affects the original funding gap.

3. **"How will government cuts to council funding affect ASC in London through to 2020?" and**
4. **"By how much / how many percent would councils have to raise Council Tax to offset this loss?"**

There is no doubt that the settlement and its reduction in core funding puts extreme pressure on London's borough councils. In Table 2, the combined local government settlement for London boroughs indicates core funding will fall nearly 30% - or 34.2% in real terms - between the current financial year (2015-16) and 2019-20. The impact of this reduction across London varies considerably by borough, ranging from a real terms cumulative loss of 68.7% for Richmond upon Thames to a loss of 24.5% for Newham. For the past several years, most councils have protected spending for adult social care whilst cutting back spending for other services. The estimated gross expenditures in Figure 1 above are based on historic patterns of funding, and these patterns show that adult social care has represented about 16% of London councils' expenditure on services.

Table 2: The decline in core funding to London Boroughs, 2016-17 to 2019-20

Financial year	Core funding (£ millions)	% change	Core spending power	% change
2015-16 (adjusted SFA)	3833.4		6816	
2016-17	3398.5	-11.3%	6608	-3.5%
2017-18	3076.8	-9.5%	6505	-1.6%
2018-19	2896.8	-5.8%	6538	0.5%
2019-20	2717.7	-6.2%	6688	2.3%
Five-year cumulative funding change		-29.1%		-1.9%
Real terms cumulative funding change		-34.2%		-8.9%

Source: Proposed Local Government Settlement funding assessment, December 2015; core spending power includes income from council taxes, business rates, an additional 2% precept for social care, BCF and a New Homes bonus.

[4] London Councils, submission to the Comprehensive Spending Review, September 2015

How councils will respond to the five-year cumulative funding change and what this will mean for social care expenditures is not certain. The government's aim is for local councils to replace the loss of core funding by increasing local tax revenues.[5] In the most optimistic scenario, if councils were to maintain the 16% spending pattern, and raise all anticipated revenue (the 2% precept plus an increase in the tax base and a 2% rise in tax rates each year), local spending cuts would have to be approximately 2.0%, possibly achieved through efficiency savings.

The behaviour of individual councils in response to their unique pressures and funding cuts, and their willingness to raise council taxes on top of the precept, will ultimately determine how government cuts have affected local social care expenditures. Unlike the NHS, social care is not a universal system, and how much is spent locally is entirely dependent on local budget decisions.[6] If different choices are made, and social care spending becomes a smaller proportion of ever diminishing local resources, then even deeper cuts will have to be made (i.e., greater than 2%). These cuts will undoubtedly have an impact on access to publicly funded care, resulting in a reduced number of users and growth in unmet need.

5. "How will cuts to ASC likely impact upon the NHS, i.e., can we say how big the additional NHS bill will be?"

Evidence from the King's Fund, the Nuffield Trust and the Health Foundation suggests that cuts in social care funding have had an impact on the NHS, but trends are difficult to interpret and it is difficult to quantify the effect for a number of reasons.[7] Although the NHS is good at tracking activity data, without a unified dataset or shared electronic record, we lack information about how users of publicly funded social care are using healthcare services. Data about self funders of social care are also not captured. Research about the substitution effect, whereby social care users are less likely to use hospital care, suggests this applies only to those in residential care rather than those receiving social care at home. No studies have directly attributed social care spending reductions to specific increases in NHS costs.

Nonetheless, the inter-relationship between health and social care services has been demonstrated in the literature. The NAO suggest that delayed discharges into, and avoidable admissions from, social care place increased demand on acute services.[8] Social care cuts potentially affect hospital A&E departments in two ways: 1) increasing older people's vulnerability and risk of admission; and 2) delaying discharges, creating knock-on effects through the whole hospital. When patients cannot be discharged in a timely fashion, patient flow is slowed or blocked across wards all the way to A&E. This situation adds unnecessary costs to the system, because the patients remaining in hospital could be cared for less expensively if discharged elsewhere.

Figure 3 below, a chart reproduced from the King's Fund Quarterly Monitoring Report, illustrates the changes in delayed discharges over time (delayed transfers of care).[9] Figure 4, also reproduced from the King's Fund, illustrates the total delayed days by organisation responsible - the NHS, social care or both.

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[5] David Phillips, Institute for Fiscal Studies, "Local government and the nations: a devolution revolution?", December 2015.

[6] Holly Holder, Nuffield Trust blog, presents evidence of a "picture of increased rationing of social care in response to deep cuts", March 2014.

[7] Nuffield Trust and the Health Foundation, Quality Watch, 2014; Ruth Thorlby and Holly Holder, "Focus on: social care for older people", Nuffield Trust, March 2014; Richard Humphries, "The Coalition Government's Record on Social Care", King's Fund, March 2015.

[8] National Audit Office, "Adult social care in England: Overview", March 2014.

[9] King's Fund Quarterly Monitoring Report 17, October 2015.

Figure 3: Delayed transfers of care (reproduced from the King's Fund Quarterly Monitoring Report 17, October 2015)

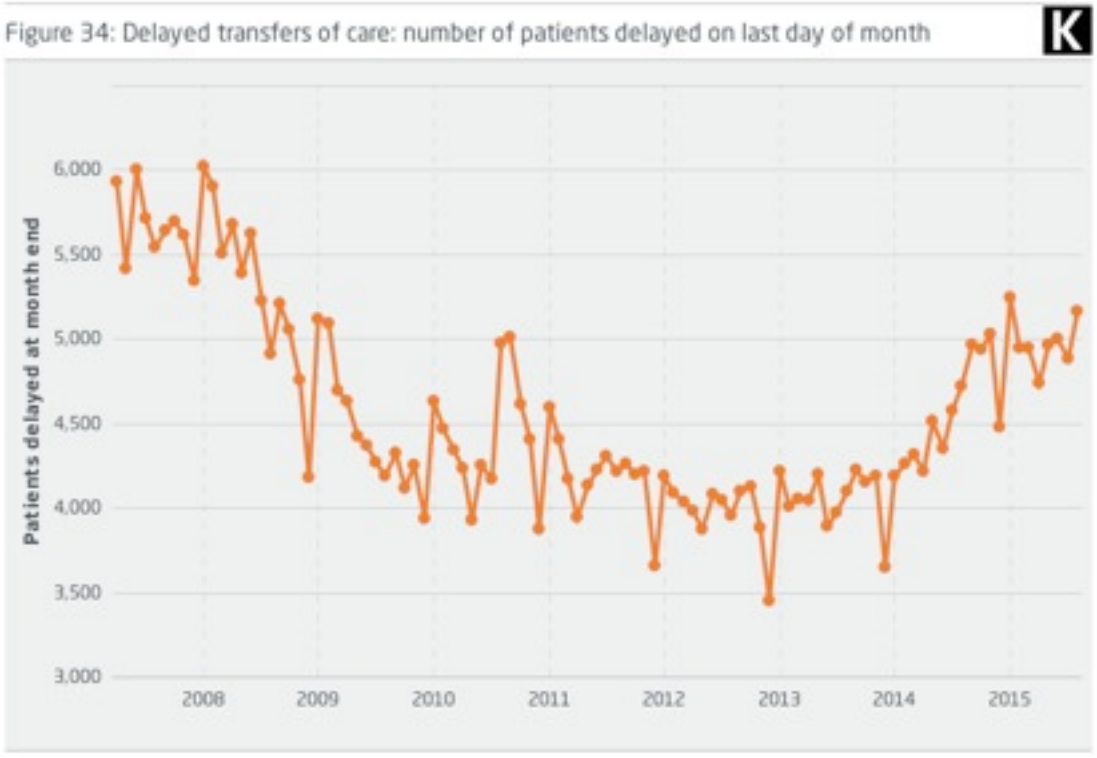
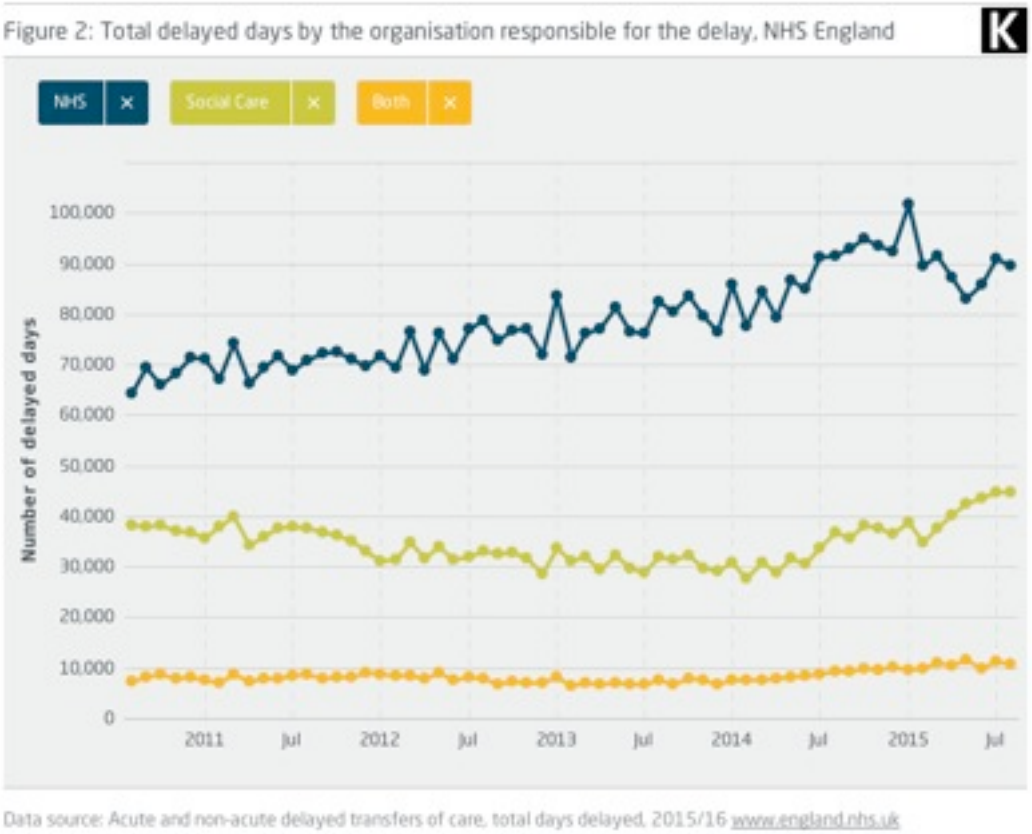


Figure 4: Total delayed days by organisation responsible (reproduced from the King's Fund)



Nationally, the numbers of delayed discharges rose 43% between 2010-11 and 2014-15. Interestingly, for this period, the number specifically attributable to social care fell by 11%, yet the biggest reasons for delays were essentially for reasons of ongoing care needs, e.g., "waiting for nursing home placement"(up 40%) and "for home care to be put in place" (up 49%). At the same time, there was a fall of 34% "awaiting public funding".

More recent data suggest delays are rising, and there is a reversal of earlier trends. By the first quarter of 2015/16, days delayed because of a wait for a nursing home placement was up 21% from the previous year; days delayed for those awaiting a care package at home were up 76% from the previous year. In addition, delayed transfers of care attributable to social care have gone up again, with a rise of more than 21% between August 2014 and 2015.[10] The delayed discharges could be a reflection of a lack of provider capacity or the lack of individual resources (self-funding). Many care recipients are delayed because they are awaiting a care package in their own home.

Some data suggest also a growing demand on GPs, with the average number of consults per year for older people rising; this may be an effect of the way GPs have been incentivised to provide more frequent health checks and monitoring of chronic conditions (not a bad outcome, in other words). Other data suggest social care cuts have reduced the number of people receiving community services. Between 2009-10 and 2013-14, the Nuffield Trust analysis suggests 16% spending cuts in social care resulted in almost 300,000 fewer adult adults receiving community services.[11] This translates into rising numbers of people with unmet needs, increasing their vulnerability and risk of a hospital admission.[12]

As the King's Fund's chief economist argues, the additional pressures on the health service are likely to continue because of the tightening spending plans in both health and social care.[13] The needs of older people in particular will continue to exceed the system's capacity. With the NHS also facing considerable financial strain, it is difficult to separate out the effects of social care spending reductions from the general problem of underfunding the health service, with funding not keeping up with either growing demand or healthcare inflation (4%). London's hospitals in particular are working at and beyond capacity, with A&E targets regularly breeched and very high occupancy rates.[14]

In order to answer the question posed, a more detailed study would be needed to attribute London-specific adult social care spending cuts on NHS trust activity levels and rising costs. Nonetheless, local councillors may want to keep a close watch on London hospital data to monitor how social care cuts might be affecting the health service over time, including the following indicators:

- delayed transfers of care (number of discharges and the numbers of days delayed), especially those attributable to social care and those awaiting a care package at home
- the number of patients in hospital with long stays (e.g., over 8 days)
- numbers of avoidable admissions - emergency admissions and readmissions for people over 65 (and over 75)
- A&E closures, possibly a sign of patient flow problems
- occupancy rates for local hospitals

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[10] King's Fund, Quarterly Monitoring Report 17, October 2015

[11] Sharif Ismail, Ruth Thorlby and Holly Holder, "Focus on: social care for older people", Nuffield Trust, March 2014.

[12] Jill Mortimer and Marcus Green, AgeUK Briefing: "The Health and Care of Older People in England 2015", October 2015.

[13] John Appleby, Data Briefing: "UK's health and social care spending plans: more of the same?", BMJ, 2015;351:h6458.

[14] Health and Social Care Information Centre, monthly Hospital Episode Statistics, April - September 2015.

6. "By how much does the optional 2% ASC precept close the social care funding gap?"

As part of its pre-CSR submission, noted above, London Councils estimated a cumulative funding gap of over £2.4 billion by 2020. These numbers have now been revised following the CSR and settlement. Although the cumulative figures have lowered to £1.7 billion, an annual gap of at least £700m is still expected by 2020. The key question is how much of the gap might be filled by receipts from the new 2% social care precept.

Table 3 below illustrates the effects of the precept, along with the Better Care Fund income, using the revised London estimates. On its own, the precept is insufficient to close the funding gap. The table's Better Care Fund amounts are London's share of the additional £1.5b funding announced in the CSR.[15] The effect of the new Better Care Fund monies is phased, beginning in 2017-18, and is not fully realised until 2019-20. Even with this additional funding, the social care spending gap remains.

Table 3: The impact of the 2% precept and the Better Care Fund on the social care funding gap in London, 2016-17 to 2019-20 (in millions of £)

	2016-17	2017-18	2018-19	2019-20	Cumulative total
Estimated funding gap for London	123	335.5	532	744	1734
Potential revenue from the 2% precept	55.1	112.2	171.2	232.4	571
Better Care Fund	0	21.7	140.1	247.4	409
Additional revenue (precept + BCF)	55.1	133.9	311.3	479.8	980
TOTAL: New estimated funding gap	67.9	201.6	220.7	264.2	754

Sources: Estimated funding gap and revenues provided by London Councils based on the Local Government Settlement Funding Assessment (December 2015); includes an assumption of a tax base of 1.5% and Council Tax rate of 1.99%. The estimated funding gap has been revised from earlier estimates.

At its most optimistic, the settlement assumes full uptake of the precept and the full impact of new monies for the Better Care Fund. We estimate that by 2020, there will be a cumulative £1.7 billion hole in funding for adult social care across London. If every London council were to levy the government's new 2% precept and optimise Better Care Fund income as well as all potential council tax receipts, the gap shrinks by £980 million, but this still leaves a cumulative gap of £754 million.

The gap may end up being higher by 2020, and the implications for individual councils will vary because the core spending cuts affect each council differently. The decision to raise revenue through the precept is inevitably a local one. The Institute for Fiscal Studies estimates that the additional funds raised will cover less than 10% of social care costs in some areas and almost 18% in others.[16] For example, their figures suggest Richmond will be able to raise close to 15% of social care funding, but Hackney will raise only about 7%.

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[15] The Spending Review included an additional £1.5b as part of an "improved" Better Care Fund. This is on top of allocations already planned in each local area.

[16] David Phillips, Institute for Fiscal Studies, "Local government and the nations: a devolution revolution?", December 2015.

7. "How will these changes to the way social care is funded, along with the ongoing funding gap, affect the people who rely on ASC services?"

Social are spending cuts are likely to have an adverse effect on some typical care recipients and their carers. A few hypothetical vignettes are used to illustrate what might happen to individuals who depend on publicly funded support. Some illustrate the impact on quality of life as well as quality of (and access to) care. They demonstrate that care needs are met through a combination of public and family resources, and that additional funding cuts will result in a greater reliance on informal caregiving and personal means. The vignettes also illustrate the inter-relationship between health and social care services.

Miss A, a 33-year old woman with learning disabilities currently living on her own

Miss A has been living independently for nearly 8 years, and a support worker helps her with managing her bills, her money and benefits. Social care cuts mean the loss of her support worker, leaving her unable to manage on her own. She quickly goes into debt and is at risk of losing her independence. She becomes increasingly isolated and anxious about her future.

Mr B, a 23-year old man with mobility difficulties currently living with his parents

Mr B receives a package of community services that enable him to build skills, maintain his confidence and enjoy a circle of friends. He attends a day centre where he receives a variety of therapies and attends classes. Following cuts in social care funding, charges were introduced for some services, such as transportation. His day center has now had to close because it could not afford to stay open, with rising wage costs and a dependence on public funding. The result for Mr B has been devastating, resulting in set-backs physically and emotionally as he became increasingly stuck at home. The burden on his family caregivers increased, and his mother took early retirement to cope with the loss of support.

Mrs C, an 82-year old woman with dementia and incontinence who is cared for by her 83-year old husband at home

Mrs C has been suffering from dementia, heart disease and other chronic care needs for several years. Her husband, Mr C, has been able to care for her at home with the support of social services, including a daily care worker who helps with his wife's bathing and toileting needs. This home support was reduced to shorter and less frequent visits following the funding cuts. As a result, Mr C was less attentive to his wife's toileting, and she developed an infection that required emergency care and an emergency admission to hospital. After a week's stay in hospital, Mr C is waiting for his wife to be discharged home, but there are delays getting extra home care in place. Mrs C has become increasingly disorientated with the longer stay in hospital, and her physical condition has worsened. Mr C may no longer be able to take care of her at home, and he is afraid of losing his savings, which he depends on, if he has to put his wife into a care home.

Mr D, a 79-year old man with COPD living independently at home

Mr D has been receiving a care package at home for two years, and he continues to visit he GP about once a month, sometimes more. With his breathing deteriorating, he had been assigned to a community nursing team, which was supposed to be monitoring his care needs and helping him stay out of hospital. He has also received domiciliary care support, and until recently, his care workers were checking in on him daily. The social care cuts reduced his daily home support to less than two hours per week, and Mr D has tried to manage on his own. He has had no other means of support and became socially isolated. Because he doesn't like "to bother" the nurses when he feels poorly, his condition deteriorated and he recently fell, breaking a wrist and two ribs. This left him incapacitated and in hospital, where his discharge has been delayed by a lack of intermediate care beds.

Mrs E, a 76-year old woman with severe arthritis, mobility problems and depression cared for by her 52-year old daughter at home

Mrs E has been receiving care at home and in the community for the past two years. Her daughter supplements social services with unpaid care every day and uses her personal resources to fund extra care at weekends. Until now she has been able to continue working part-time. The stress of caring for her mother as well as her own teenage children has been mounting and has taken a toll; she has visited her own GP for help with her mental health needs. As the amount of social care support has diminished, Mrs E's daughter has noticed an erosion in the quality of care and a rapid deterioration in her mother's physical and mental condition. Fearful of a further decline, Mrs E's daughter decides to leave her job in order to care full-time for her mother. The loss of income adds to her personal burden, and she is worried about her family's economic viability.

Mr F, a 90-year old man with multiple chronic conditions living in a care home

Mr F has lived in a small, independent care home since he wife passed away eight years ago. He is visited regularly by his niece and nephew, who live in London. The cuts in social care, rising wages and rising costs have resulted in terrible losses for the care home business, and the local authority has now been alerted that whey will be closing down. The local authority will have to find a new bed in a new care home for Mr F, but occupancy rates in nearby homes are high and no bed is available. The council has to consider moving him to a care home outside of London. This risks Mr F becoming isolated from his family, and he may suffer from the move out of familiar surroundings.

8. Conclusions

Together, the CSR and local government settlement highlight an important shift in responsibility for social care funding from central government to local councils. Although the full effects of the new spending cuts on London social care expenditures can only be estimated, the significant 30% reduction in core funding accompanied by rising demand and rising care costs suggests difficult decisions will have to be made by local councils about how to respond in the short term.

Councils are expected to make up these losses to retain their "core spending power" through local tax increases. This includes a combination of income generating options: maximising council tax receipts, possibly including an annual increase; raising another 2% in council tax through the social care "precept"; and retained business rates. On top of the precept, the additional Better Care Fund monies, as promised in the Spending Review, are expected to contribute to social care spending, although this source of income kicks in only in 2017-18 and benefits are not fully realised until 2019-20. The obvious choice is for councils to use their revenue raising options. The additional revenue raised, plus the extra Better Care Fund monies, might mitigate some of the pressures, although not in the same way for every London borough.

This analysis concludes that the precept is insufficient on its own to close the growing gap between social care demand and available funding. Partly because of how it is phased, one might also say that the additional monies promised for the Better Care Fund are too little, too late. There is likely to be a cumulative funding gap of about £750 million if both the precept and additional Better Care Fund monies are counted, and a gap of £1.7 billion if not.

Most important, the precept represents neither a short-term nor long-term solution to the mismatch between demand for social care, demographic changes, inflationary pressures on the costs of care (including the rising minimum wage) and available funding.[17] It is highly likely the funding gap will continue to grow. A related conundrum is the political difficulty convincing the public that there is a robust business case for raising council tax to fund social care, particularly if the tax is accompanied by social care eligibility changes, restricted access to care and a perceived decline in the quality of care.[18]

Notwithstanding the efficiencies already realised in the past five years, the way social care is currently funded is not sustainable, and fairness and equity remain concerns. In addition to raising taxes, councils will need to consider new ways to reduce demand, increase the productivity of social care services and maintain quality of care. Options include further health and social care integration, alternative delivery models, devolution and "place-based systems of care", restricting access by limiting eligibility for publicly funded care or requiring greater personal contributions from individuals and their families. Many of these solutions require close collaboration with local NHS partners.

Exactly by how much each of these approaches would alter social care expenditure cannot easily be quantified because too many factors are involved. Other than restricting eligibility and shifting more costs to service users, none of the options produces immediate short-term savings. The LGA and ADASS have commented that additional reductions in unit costs risk destabilising the provider market and reducing access to services further.

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[17] Richard Humphries, "Where does the spending review leave social care?", Health Service Journal, 14 December 2015; Anita Charlesworth and Ruth Thorlby, "Reforming Social Care: options for funding", Nuffield Trust, May 2012.

[18] Anita Charlesworth and Ruth Thorlby, "Reforming Social Care: options for funding", Nuffield Trust, May 2012.

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