Communities and Local Government and Health and Social Care select committee: Long term funding of adult social care inquiry

Submission by NHS Providers, March 2018

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has 99% of all trusts in membership, collectively accounting for £74bn of annual expenditure and employing more than one million staff.

Key messages

- Adult social care services are facing increasing pressure from a combination of an ageing population increasingly complex care needs, rising costs, increased demand, shrinking budgets and staff shortages.
- The NHS and social care are working together to address these pressures, but integration is not a panacea, social care needs to be properly funded to ensure people are cared for in the right setting. To do otherwise is to lessen people's independence and experience of care, and to exacerbate cost pressures across health and social care.
- NHS Providers believes that the decision on how to fund – while it should be reached through engagement, consultation and consensus – is ultimately the responsibility of the Government. While commissioned locally, social care is a public service to be delivered according to need and the basis of its funding policy is set nationally.
- We welcome the joint inquiry which is a step in the right direction along with the Green Paper on social care for older people.

Pressures on social care

1. Adult social care services in England are facing increasing pressure from a combination of growing and more complex demand, rising costs and shrinking budgets, and staff shortages.

2. As England's population grows and ages, its care needs are becoming more complex and the cost of care is increasing due in part to increases in care costs and the implementation of the National Living Wage which increased to £7.50 in April 2017. The Local Government Association found that the introduction of the National Living Wage would cost the social care sector £330m in 2016/17, growing to £1b by 2020[1].

3. Most local authorities are experiencing cuts to their budgets and have had to reduce their spending on social care at a time when demand is rising. Since 2010, local authorities have seen a 38% fall in their overall grant from central government. Between 2009/10 and 2015/16, spending by councils on social care per adult resident fell by 11% in real terms, and over the same period the number of people receiving publicly funded social care services fell by 400,000, due in part to local authorities applying a stricter application of eligibility criteria.[2]

4. At the same time as demand is increasing, many social care providers are struggling to recruit and retain the staff they need to deliver high-quality care. Key contributory factors are low staff

[1] http://www.communitycare.co.uk/2015/07/13/living-wage-cost-councils-extra-1bn-year-2020-warns-lga/

[2] https://www.kingsfund.org.uk/sites/default/files/2018-03/Approaches-to-social-care-funding.pdf

morale and pay, with anecdotally a care worker receiving more money working a minimum wage job, for example in a supermarket, than the equivalent number of hours working in a care home. The continuing uncertainty around immigration and residency post-Brexit has added to the pressures that providers are facing, with EU staff leaving or not joining the UK workforce. The number of EU nationals joining the Nursing and Midwifery Council register from the EU has dropped dramatically by 89 percent[3].

5. As a result of these pressures, social care providers are facing quality challenges and the care provider market is becoming increasingly precarious.[4] The Care Quality Commission has suggested that there is a significant risk of "*a tipping point*" in adult social care,[5] "*where deterioration in quality would outpace improvement and there would be a significant increase in people whose needs weren't being met*"[6]. This was based on evidence from CQC inspections on quality, bed numbers, market fragility, unmet need and local authority funding.

Interdependence of health and social care

6. We need an adequately funded social care system for the reasons set out below; social care and the NHS are interdependent and both are at a tipping point, the NHS absorbs the pressure where social care is harder to access and this has a substantial impact on trusts.

7. Social care and health care are highly interdependent and each plays a key role in ensuring that people are supported in the right setting at the right time. For example, when people receive adequate and timely social care at home or in the community, it is better for the patient and can help avoid hospital admissions which are both costly and intensive, and which for some service users can lead to a loss of independence. The ready availability of social care can also help avoid delays in hospital discharges.

8. Unplanned delays can have a considerable adverse impact on someone's functional ability. In a mental health setting, extended length of stay can lead to deconditioning, functional relapse and a loss of confidence. In an acute setting, at its most basic, time is muscle; older people can lose significant muscle power in as little as half a day in hospital. This can be the difference between being able to stand unaided and having the confidence to return to independent living. Likewise, accessible social care provision means that NHS capacity – in terms of both beds and staff – can be best utilised for those who need medical care.[7]

9. Conversely, where social care is harder to access, the NHS often absorbs the pressure as the need continues. The impact can be seen in the increasing level of delayed transfers of care (DTOCs) in recent years, and also in emergency admissions. In December 2017, there were 145,300 total delayed days, equivalent to 4,688 daily beds occupied by a patient who was delayed in transferring, up from 4,485 in December 2014.[8] Over a third of those delays were due to an inability to access social care packages. In its February 2018 report on the adult social care

[3] https://www.nmc.org.uk/news/news-and-updates/increasing-number-nurses-midwives-leaving-profession-major-challenges/

[4] http://researchbriefings.files.parliament.uk/documents/CBP-7903/CBP-7903.pdf

[5] CQC Report: The state of health care and adult social care in England 2016/17

[6] CQC Report: The state of health care and adult social care in England 2016/17

[7] http://nhsproviders.org/resource-library/reports/right-place-right-time-better-transfers-of-care-a-call-to-action

[8] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/02/December-17-DTOC-SPN-25po0.pdf

workforce, the National Audit Office (NAO) found that one fifth of emergency admissions to hospital were for existing conditions that primary care, community or social care could manage.[9]

10. Such delays and avoidable admissions have a substantial impact on trusts, both financial and in time spent. The NAO estimates that the gross annual cost to the NHS of keeping older patients in hospital who no longer need to receive acute clinical care is around £820m.[10] DTOCs can disrupt patient flow through the NHS with, for example, patients arriving at A&E then waiting longer for treatment or admission because there are fewer beds available elsewhere in the hospital. We welcome the Public Accounts Committee's recommendation that NHS England and the Department of Health and Social Care *"assess the impact that financial pressure in social care is having on the NHS, so that it can better understand the nature of the problem and how it can be managed".*[11]

Addressing the pressures

11. There are a number of examples of the NHS and social care working closer together to address these issues. For example, it is common for trusts to have older people's social work discharge teams based onsite at hospitals to help with a smooth transition when people are leaving hospital and moving on to other care settings.

12. Closer organisational working also offers opportunities for improving transitions between health and social care and ensuring people are cared for in the right setting. NHS care trusts and their successor organisations have offered a range of health and social care services for a number of years, and integrated care models will similarly be better positioned to drive joined-up working. For example, in areas with high levels of existing integration, some staff have mixed roles – such as district nurses with a social work qualification – helping to create a seamless experience for patients and service users. Elsewhere, NHS providers have taken responsibility for commissioning and/or delivering social care.

13. Nevertheless, integration is not a panacea. Health and social care have been charged with wide-ranging transformation despite both services facing challenges to their financial sustainability. Bringing the two closer together will not in itself resolve the fundamental question of funding levels and allocation. For example, DTOCs have reduced over the last 12 months, but this is not the full story, as DTOCs remain persistently higher than the national target[12] and the NAO found "no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity"[13] in their report on health and social care integration.

14. Moreover, we should recognise the fact that the NHS is increasingly involved in social care. The emphasis should be on the benefits to patients and service users of integration, and not the benefit to balance sheets of the NHS absorbing displaced demand from social care. The initiatives of recent years to rebalance funding, such as the Better Care Fund (BCF) and then the improved Better Care Fund (iBCF) have helped to forge closer links, but cannot by themselves deliver more integrated care, better services or significant financial savings, as was found by the Public Accounts Committee in their report on integrating health and social care[14]. Social care

[9] https://www.nao.org.uk/report/adult-social-care-england-overview-2/

[10] https://www.nao.org.uk/report/discharging-older-patients-from-hospital/

[11] House of Commons Committee of Public Accounts, Integrating health and social care, 27 April 2017

[12] https://www.kingsfund.org.uk/blog/2018/01/delayed-transfers-care-target-misses-mark

[13] https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

[14] https://publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/959/95902.htm

needs to be properly funded to ensure people are cared for in the right setting. To do otherwise is to lessen people's independence and experience of care, and to exacerbate cost pressures across health and social care.

15. NHS Providers believes that a number of fundamental principles need to be adhered to in reaching a sustainable settlement for NHS:

    a. The NHS must remain free at the point of use.

    b. There needs to be a dialogue between national and local bodies, and the government and independent bodies, and the public and NHS and social care services, to assess patient and service user need.
    c. Funding must be sufficient – as the population grows and ages, as public and government expectations change, as technology and infrastructure both develop and depreciate, funding levels need to be adjusted accordingly.

    d. Funding must be recurrent – the NHS needs to be able to plan and invest, maintain and evolve, its services. It can only do so with predictable and sufficient funding levels appropriate to the task at hand.

    e. Healthcare costs cannot be considered in isolation – social care and the wider determinants of health (from public health and prevention, to workforce training, to education and housing) must be factored in.

16. A similarly principled approach –while acknowledging the likely mix of self- and state-funding – must be adopted for social care. Within that, where and how the line is drawn on self-funded social care will necessarily affect the NHS and so the likely impact on the NHS needs to be assessed in advance.

17. The mix of local government funding sources will continue to change in the coming years, away from central grants and towards local business rates. There is a considerable risk that this will put further pressure on budgets at a time when – for social care to avoid falling over the precipice – local government must be able to ensure a continuing service at adequate scale with an appropriately sized and skilled workforce. Significant capacity has already been lost and rebuilding this will require concerted investment. At this point, further eroding the capacity of the social care sector is likely to have an accelerating effect, reaching the tipping point of sustainability faster. The impact on the NHS also needs to be taken into account given their interdependence: when social care provision is cut, the NHS also bleeds.

18. As with the NHS funding settlement, NHS Providers believes that the decision on how to fund – while it should be reached through engagement, consultation and consensus – is ultimately the responsibility of the Government. While commissioned locally, social care is a public service to be delivered according to need and the basis of its funding policy is set nationally.

19. Since 1998 there have been 12 green papers, white papers and government consultations, as well as five independent commissions, all looking at funding of social care. We would particularly note the Dilnot and Barker reviews as providing comprehensive analysis of the problem and potential solutions. In addition Lord Darzi has embarked on a review with IPPR which will look at funding and reform of the NHS and social care. We hope that the Committee will draw on this work in its welcome inquiry, and help advance an answer to a problem that successive governments have shied away from.