



November 2015

Statement

It is a year since the Commission on the Future of Health and Social Care in England published its final report calling for 'a new settlement' for health and social care in England. We write now out of a deep concern at the many signs that - far from social care and its funding being simplified and improved, as we recommended - the care system is instead crumbling around us. That in turn is piling more pressure onto a National Health Service that is struggling both financially and in terms of performance.

The government appears now to have no strategy whatever to tackle the rising and pressing needs for social care.

We called last year for a single, ring-fenced budget for health and social care, with a single commissioner. We declared that a much simpler pathway must be created through the whole of the health and social care system: one that provides more equal support for equal need, and one that reduces the current confusion, perverse incentives and distress that the current system creates for families and carers.

We acknowledged the current difficulties over the public finances and the need, over time, to eliminate the deficit. But we also called on the government to plan on the assumption that spending on health and social care is likely to rise to between 11 and 12 per cent of GDP by 2025 - a level of public expenditure that is already being met, for health alone, in many other developed countries. We also pointed to a number of ways that finance could be raised, or expenditure shifted, to contribute to that.

The Commission on the Future of Health and Social Care in England was created as an independent body by The King's Fund because of the mounting evidence that both health and social care were heading towards a crisis. Since its final report was published (2014), the situation has moved from bad to worse.

We start with some good news. NHS England and other national bodies have published the *NHS five year forward view* (NHS England *et al* 2014). This sets out a number of new models of care, many of which seek to bring the operation of health and social care closer together. The vanguard programme and other initiatives are aiming to make that a reality. In Manchester, there is a bold and imaginative drive to bring together all of the £6 billion health and social care budget so that the two are jointly commissioned. Other parts of the country are pursuing similar ideas. We welcome these initiatives, although we question whether their potential can be fully realised without the single, ring-fenced budget that we recommended. The health part of this spending remains ring-fenced. The social care part has no such guarantee.

The government has also committed to 'parity of esteem' between physical and mental health, and the coalition government's final Budget committed a modest £1.25 billion over five years to help achieve that.

The NHS five year forward view also lays out how the NHS hopes to close a gap in health spending that is estimated to reach £30 billion a year by 2020. The NHS aims to do this by achieving efficiency savings to the value of £22 billion, while arguing that the service will need at least an additional £8 billion a year of real additional funding by 2020. The government is committed to funding 'at least' that £8 billion, although the timing of the increase has yet to be established and doubtless forms part of the negotiations for the Spending Review that is due to be published later this month. We would underline, however, as Simon Stevens, Chief Executive of NHS England, has repeatedly stressed, that these very broad calculations of what will be needed depend on social care receiving a decent level of funding, given that cuts to social care expenditure inevitably increase the pressure on the NHS.¹

¹ 'One of the important provisos' attached to the £8 billion figure, was 'that there was not a further substantial offset in the availability of social care across the country.' Simon Stevens, Speech, NHS England board meeting, March 2015

That is the end of the good news - and it is outweighed by a far greater volume of bad news since our final report was published.

An ageing population means that demand continues, inevitably, to rise (Office for Budget Responsibility 2015); yet local authority expenditure on social care continues to fall. Compared to 2009/10, some 400,000 fewer people - a quarter fewer - are receiving adult social care. Many of those still receiving it are getting less support than they were, and spending on prevention that can cut future bills has had to be reduced (ADASS 2015). Prevention has also been hit by a £200 million reduction in spending on public health, a cut that may well cost the health and social care system more in the long run than it saves in the short term.

Figures from the Health and Social Care Information Centre show that councils made a 14 per cent real-terms cut in adult social care spending between 2009/10 and 2013/14, with a further reduction of 3 per cent in the current financial year. These figures also show that fewer than 10 per cent of directors of social services are fully confident that they can make the further savings expected of them over the next two years. The transfer of funding - including the Better Care Fund - from the NHS to social care has been growing and now totals more than £3 billion a year. The effect of that has been to reduce the real-terms cut to social care funding over the four years to 2013/14 from 14 per cent to 9 per cent (The King's Fund 2015).

But there is no salvation for the health and care system in continuing this 'robbing Peter to pay Paul' approach.

All it has done is to lessen the impact of social care cuts but at the expense of placing further pressure on already stretched NHS budgets. Indeed the NHS has seen a net loss from this funding transfer, given that the cuts to social care have been larger than the transfers from the NHS.

This policy cannot continue, not least because of the NHS's own financial difficulties.

Given the exceedingly limited growth that the NHS has enjoyed since 2010, it has performed remarkably well. But it is now struggling to meet many of its waiting time and other targets - even in the months of the year when these are more easily achieved - and its finances are under acute pressure. The target for diagnostic services has not been met for 18 months, the 62-day cancer waiting time target has not been met for more than a year, and waiting time performance in accident and emergency departments is back to the levels of 2004. The NHS did balance its books in the last financial year, but only through a £640 million transfer of capital to revenue, along with an additional subvention from the Treasury, while the Department of Health as a whole came close to exceeding the amount allocated by parliament. Forty-six per cent of NHS organisations ended the financial year with a total gross overspend of £1.25 billion. A King's Fund survey shows that 89 per cent of finance directors in acute trusts believe they will end the current financial year in deficit. The figures for the first quarter of this year show more than eight out of ten NHS provider organisation overspent and there was a net deficit of £930 million. Projections of the likely overall end-of-year deficit vary but on some estimates it could reach £2.5 billion.

Matters are even worse in the local authority sector. More social care services are failing to meet the Care Quality Commission's (CQC) standards. In October last year the CQC reported that one in five nursing homes did not have enough staff on duty to ensure good safe care (CQC 2015), and its board has recently been informed that the services of almost one in three adult care providers 'require improvement' (Paterson 2015).

We are reaching the stage where staff shortages mean that good people cannot provide good care.

Council spending cuts have seen fees for care home places frozen or reduced for many years now, and the five largest care home providers have warned that 'many people in the sector foresee significant provider failure as likely within 12-24 months'. The latest annual market survey from LaingBuisson shows that for the first time since it started collecting figures in 1990, more older people's care beds have closed than opened. In the six months to March 2015, there was a net loss of 3,000 from the total of around 487,000 beds spread across the United Kingdom (LaingBuisson 2015). In the face of rising demand, this situation is set to get worse. Three of the larger providers have already withdrawn or signalled their intention to withdraw from publicly funded home care, and in a joint letter to George Osborne the five largest say: 'Our words are chosen carefully but we see an approaching shortfall of tens of thousands of places for older people as aged care providers - both large and small - cease their operations.' It is easy to see, they observe, the impact that even a small percentage loss of care home beds would have on the NHS.

Nor are things about to get better. The National Audit Office has warned that council auditors 'are increasingly concerned about local authorities' capacity to make further savings, with 52% of single tier and county councils not being well-placed to deliver their medium-term financial plans' (National Audit Office 2014).

While council budgets face further cuts, both care home providers and those that provide care in people's own homes will be expected to meet the government's drive to provide 'a national living wage'. That initiative is one we warmly welcome. Pay in the sector is distressingly low. But that commitment has to be funded if services are to continue and not be withdrawn. The United Kingdom Home Care Association has calculated that, even with other offsetting tax changes, the national living wage will add more than 20 per cent to the amount that councils would have to pay per hour in the first year of its operation, compared to now (UK Home Care Association 2015).

The government has also dropped the policy developed during the coalition, and which was clearly in the Conservative 2015 manifesto, of implementing the Dilnot reforms.² It has done so partly at the request of local authorities, who believe the initial costs of the reform to cap care costs would be better spent supporting current services. We fear, however, that a postponement of the reforms to 2020 is likely to become a permanent one. There is as yet no guarantee that the estimated £6 billion a year of additional spending that Dilnot would have required over the next five years will in fact be injected into the current system.

The Dilnot reforms were not intended to address under-funding. Rather they represent a form of stop-loss insurance – capping the exposure of more affluent individuals to long-term care costs. But one effect of the under-funding of publicly supported care is that 'self-funders' – those in residential and nursing homes who are sufficiently affluent to pay their own fees – are now paying an average premium of 40 per cent above local authority funded rates (County Councils Network 2015). There has always been an element of cross-subsidy between self-funders and those supported by the public purse. This cross-subsidy, however, is clearly rising so that, rather than taxpayers as a whole supporting those in need of social care who do not have the funds to provide for themselves, a sub-group of the more affluent who, through no fault of their own are unfortunate enough to need long-term care, are now increasingly providing that subsidy. This is profoundly inequitable and a long way from 'we are all in this together'.

What all this points to is a health and social care system living in the midst of a crisis that will only get worse. Its practical effects will be increasing evidence of declining service quality and unmet need in both the health and social care sectors. Using official statistics and the English Longitudinal Study of Ageing, Age UK has calculated that more than a million people who have difficulties with basic activities of daily living, such as getting out of bed, washing and dressing, now receive no formal or informal help at all. That is an increase of 100,000 in one year alone (Age UK 2015).

Indeed, with the postponement of the Dilnot reforms – and despite the coalition having recognised the 'urgency' of addressing social care funding – the government now appears to have no strategy or plan to deal with the mounting pressures on social care, while having an approach to the NHS that promises only a limited amount of additional money, the timing of which remains uncertain.

All of this makes the need for a new settlement for health and social care even greater and more urgent than when we reported a year ago.

Social care funding needs to be increased and ring-fenced into a single health and social care budget that will end the debilitating transfers and disputes across the NHS and social care divide. A single commissioner needs to be developed for such budgets, allowing the simplified pathway through the system that we recommended, along with more generous social care entitlements at the higher levels of need.

Recent research from Scotland shows that the introduction of free personal care there did not, as the critics predicted, displace informal care by family and friends. Rather it encouraged the provision of more informal care. If replicated in England, more generous social care entitlements could thus have a double pay-off – increasing both formal and informal care for the really needy (Karlsberg Schaffer 2015).

As we underlined in our report last year, we appreciate that the new settlement will need to be phased in. But the country cannot continue to wait for a start to be made. Better support for the less affluent needing care is required now, as is a return to the principle of some limit on private contributions.

² Based on the recommendations of the Commission on Funding of Care and Support chaired by Andrew Dilnot, part 2 of the Care Act would have seen the introduction from 2016 of a lifetime cap on individual care costs of £72,000, an annual cap on individual living costs of £12,000 and a more generous level of means test thresholds.

The new settlement that we called for is required.

We reiterate the solutions that we set out, with some adaptation to allow for the postponement of the Dilnot reforms. This is what is needed.

- A much simpler pathway for individuals and their carers through the present maze of health and social care. Without that, money will be spent badly and there will be much unnecessary distress.
- A commitment from the government to spend between 11 and 12 per cent of GDP on health and social care combined by 2025.
- A start to be made on that by meeting the increase in NHS funding that has been promised in principle while, at the very least, stabilising social care spending initially and then increasing it.
- Using the £6 billion earmarked for the Dilnot reforms over the Spending Review period as a contribution to that, while adopting the changes that we recommended to the National Insurance system to increase expenditure further. Those changes included removing the complete exemption from employee's National Insurance for those past state pension age, increasing contributions marginally for those aged over 40, and raising to 3 per cent the additional rate for those above the upper earnings limit.
- Adopting the other measures we recommended, including restricting winter fuel payments to the least affluent pensioners. These measures would see some of the extra costs met by those above state pension age who have the means to contribute.
- Providing, as a first step towards a simpler pathway, free social care to those whose needs are defined as 'critical'.

We would stress – as we did in our final report – that the costs of health and social care will not go away. The question is not whether most of this money is spent. It is about where the costs, human as well as financial, fall – on collective provision through public expenditure, or on those individuals and families who are unlucky enough to have high, or very high, care needs.

More people in need receiving no support at all. Fewer people receiving publicly funded social care. Care home providers closing in the face of rising demand, with companies that provide care in people's own homes leaving the publicly funded market. Individuals and families who are unlucky enough to need high levels of care continuing to face enormous, and uncapped, bills. Staff shortages leading to a rise in abuse and neglect as good people are unable to deliver good care. And further pressure applied to the NHS that in turn is likely to lead to declining standards of patient care. That is a future that no one would wish for. But it is the one that is upon us.

Our simplest recommendation to the Chancellor and the Health Secretary is that they should read our report (Commission on the Future of Health and Social Care 2014). And then act on it.

Dame Kate Barker CBE

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Lord Bichard

Baroness Sally Greengross

Sir Julian Le Grand

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