Health Foundation's evidence to the Communities and Local Government Select Committee inquiry on Adult Social Care

August 2016

Health Foundation evidence

1. Introduction

1.1. Thank you for the opportunity to respond to the Communities and Local Government Select Committee inquiry on Adult Social Care. Our submission covers social care spending over the last parliament, spending over this parliament and longer-term projections on the funding needed for social care up to 2030/31. We also cover the impact changes in funding have had on older people's access to social care and the NHS. The focus of our work in this area to date has centred on social care for older people over the age of 65 rather than other working age recipients of adult social care with physical disabilities, learning disabilities or mental health problems. While our submission reflects this focus, we strongly advise the committee explores the impact changes in social care funding have had on these wider groups. Finally, our submission provides case studies from projects we have funded, which showcase how the NHS and social care services have worked together to improve the quality and efficiency of care.

2. About the Health Foundation

2.1. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

2.2. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen. We use what we know works on the ground to inform effective policymaking and vice versa.

2.3. We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

3. Key points

3.1. Reductions in publicly-funded social care over the last five years have resulted in fewer people being able to access care and support, with older people on lower incomes experiencing the greatest levels of unmet need.

3.2. Additional funding for social care through the Better Care Fund (BCF) and new powers to raise council tax by up to 2% to spend on social care are welcome. However, with pressures rising by around 4% a year - from an ageing population and the rising prevalence of chronic conditions - there is still likely to be a funding gap in 2019/20 of at least £1.7bn. This is before factoring in the additional costs associated with the introduction of the living wage and the economic impact of the UK's decision to leave the European Union (EU).

3.3. Due to limitations in the data available it is not possible to determine the precise impact budget reductions have had on the health and wellbeing of older people, nor on the demand for NHS services. However, there are certain parts of NHS care where problems stemming from the availability of social care services are having a visible impact. For example, over the last five years problems with the availability of social care have accounted for an increasing proportion of delayed discharges from hospital. For example, the fastest growing reasons for delayed transfers since 2011-12 – the first full year monthly data was collected – have been 'awaiting a care package in own home' which increased by 114% and 'awaiting nursing home placement or availability' which increased by 56%.

3.4. Policymakers need a clear understanding of the relationship between social care and the wellbeing and health of older people, and the consequent impact of cuts to social services on other public services. At present, the difficulties faced by older people with social care needs can only be partially described and the levels of unmet need – which we expect are growing – are unknown. With the rate of population growth and the financial constraints on local government and the NHS, better sources of data are needed to create a clearer picture of the care, health and wellbeing of older people in our society. This is imperative for robust accountability and effective policymaking.

3.5. There are examples of innovative projects we have funded where NHS and social care providers have worked successfully to improve the quality and efficiency of care for older people, including problems with delayed discharges from hospital. These are set out in section 8.

4. Social care spending over the last parliament

4.1. This section explores the scale of reductions in publicly-funded social care for older people in England, which occurred over the last parliament as a result of the Coalition Government's efforts to reduce public sector spending following the financial crisis in 2008.

4.2. Research by the London School of Economics (LSE), highlights that while public spending on social care has failed to keep pace with increasing demand since the mid-2000s, spending cuts imposed by the Coalition intensified the pressure on social services from 2010 onwards[1].

4.3. In 2010, central government grants to local authorities were reduced by 26% in real terms between 2011/12 and 2014/15. This was later followed by a further 10% reduction in grants for 2015/16[2].

4.4. The majority of local authorities responded by cutting spending on most categories of local government-funded activities, including social care for over-65s. Despite rising demand, in 2009/10 local authorities spent £10.6bn (in 2009/10 prices) in gross terms on social care for older people over 65, compared with £9.8bn in 2012/13 - a reduction of 7%. Total expenditure on social care for this group amounted to £9.9bn in 2013-14 and £10bn in 2014-15 – a small decrease of less than 0.5% in real terms.[3]

4.5. Overall spending is estimated to have fallen by 13.4% over the Coalition Government's five years in office. By 2013/14, 17.4% less was being spent on services for older people. By contrast, the number of people aged 65 and over increased by 10.1% over the same period, including an 8.6% increase in the population aged 85 or over.

4.6. Without transfers from NHS to social care budgets, and more significant sums transferred from the NHS to form part of the Better Care Fund (BCF)[2], some of the reductions in adult social care budgets could have been even more drastic[2].

5. Social care spending over this parliament

5.1. Spending on social care over this parliament is subject to some uncertainty. New powers to raise council tax by up to 2% to spend on social care will provide flexibility for local authorities but this is unlikely to raise as much as the government suggests and could disadvantage deprived areas with low tax bases. Additional money for social care provided through the BCF from 2017-18 is welcome, but risks arriving too late.

5.2. Together the new council tax precept and additional investment for the BCF mean that funding for adult social care in 2019/20 is likely to be higher than in 2015/16 in real

[1] Burchardt,T.,Obolenskaya, P. and Vizard, P. (2015) The Coalition's Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015. Available at: http://sticerd.lse.ac.uk/dps/case/spcc/WP17.pdf

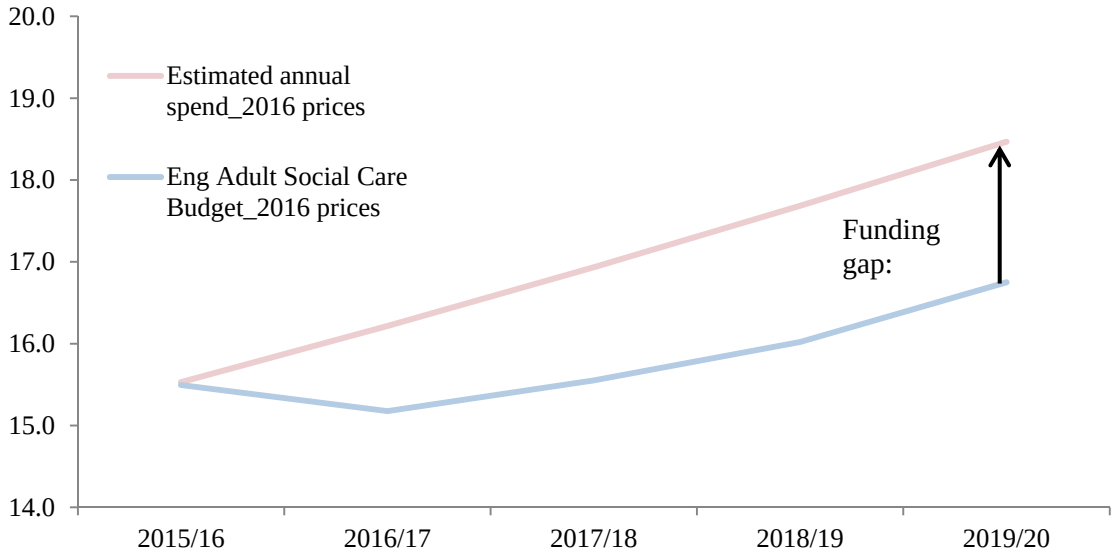
[2] Ismail,S., Thorlby, R., and Holder, H. (2014) Focus on: social care for older people. Reductions in adult social services for older people in England. Available at: http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/140326_QualityWatch_Focus_On_Social_care_older_people_0.pdf

[3] Personal social services: expenditure and unit costs – England 2014-15, Health and Social Care Information Centre (November 2015). Available at: http://digital.nhs.uk/catalogue/PUB19165/pss-exp-eng-14-15-fin-rep.pdf

terms.[4] This is despite an initial drop in the budget in 2016/17 due to the backloading of the BCF investment.

5.3. But with pressures rising by around 4% a year from an ageing population and the rising prevalence of chronic conditions, there is still likely to be a funding gap in 2019/20 of around £1.7bn, as shown in Figure 1. This is before allowing for the economic impact of the UK's decision to leave the EU. Nor does it take into account the additional costs associated with the introduction of the new living wage which could be worth another £800m (Association of Directors of Adult Social Services and Local Government Association 2015[5]).

Figure 1: Projected funding gap for adult social care in 2019/20.



6. Long-term projections of adult social care spending

6.1. Beyond 2019/20 we have assumed that public spending on adult social care maintains its share of GDP, which was projected to rise by 2.2% a year before the national vote to leave the EU. This would see the funding gap for adult social care rise to £8.2bn in 2030/31 – see Figure 3. These figures are set in current prices, are based on the Spring Budget in March 2016 and take into account the additional funding available to councils through the precept.

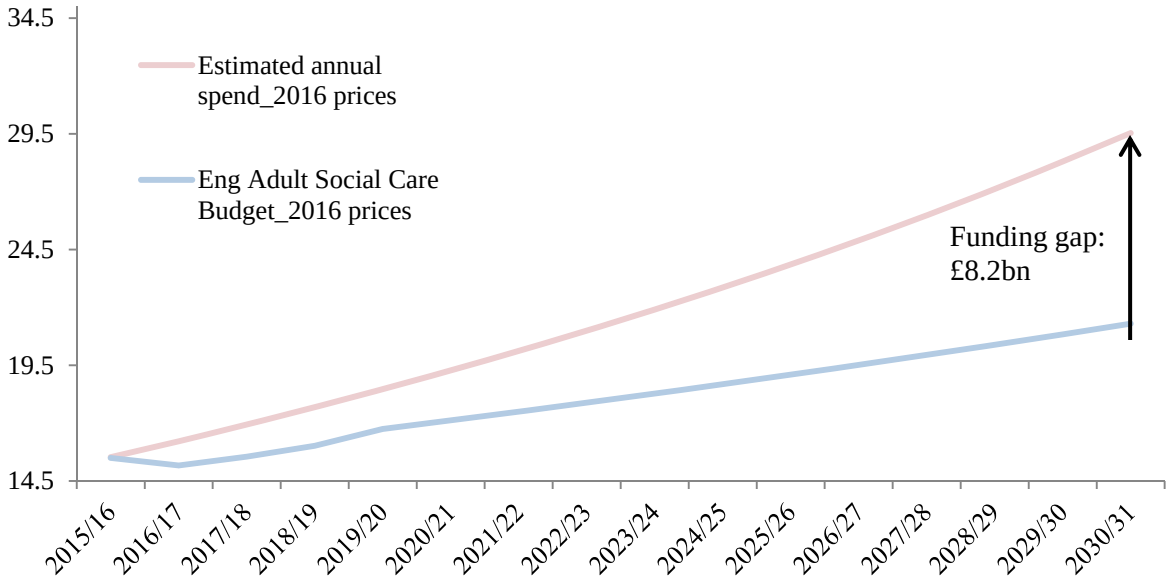
6.2. It is difficult to predict at this time the impact that the UK leaving the EU will have on social care spending. However, the majority of economists project that the referendum result will have a negative impact on economic growth and as a result it is highly likely

[4] Health Foundation, The King's Fund and the Nuffield Trust (2016) written submission to Health Select Committee inquiry on the Impact of the Comprehensive Spending Review on health and social care. Available at: http://www.health.org.uk/sites/health/files/Spending%20Review%20Inquiry%20joint%20submission%20NT%20KF%20HF%20-%20FINAL%20JOINT%20SUBMISSION.pdf

[5] Association of Directors of Social Services, Local Government Association (2015). Adult social care, health and wellbeing: a shared commitment 2015. Spending Review submission. London: Local Government Association. Available at: www.adass.org.uk/adult-social-care-health-and-wellbeing-a-shared-commitment/ (accessed on 16 December 2015).

that there will also be a detrimental impact on areas of public spending, including social care spending.

Figure 2: Projected funding gap for adult social care in 2030/31



7. Impact on access to social care

7.1. Cuts to social care budgets for older adults have been implemented in a number of ways, including: tightening the eligibility criteria for publicly funded support (which is now set nationally), increasing fees payable by users, reducing fees to care providers, and generating savings from service redesign and reduced administrative costs.

7.2. These cuts in spending have been accompanied by reductions in the number of older people receiving publicly funded services. For example, reductions in services have seen more than 400,000 people denied access to the care they need over the past five years, as the number of people receiving publicly-commissioned adult social care services between 2009/10 and 2013/14 fell from 1.7 million to below 1.3 million[1].

7.3. According to the LSE, care at home and other community-based services were hit especially hard, resulting in an average 8% reduction in the number of users each year. Local services were increasingly targeted on adults assessed as having the most complex needs. The proportion of social care clients being supported for five or fewer hours a week declined from 37% to 28% between 2009/10 and 2013/14. The proportion receiving care for more than ten hours a week increased from 34 per cent to 45%[1].

7.4. Reflecting the fragility of the provider sector, the latest annual market survey from the health care market research company LaingBuisson shows that for the first time since they started collecting figures in 1990, more care home beds for older people closed than opened. In the six months to March 2015, there was a net loss of 3,000 beds from the total of around 487,000 beds spread across the UK[6].

[6] LangBuisson. County Care Markets: Market sustainability & the Care Act. 2015. Available at: http://www.laingbuisson.co.uk/MarketReports/LatestMarketReports/tabid/570/ProductID/661/%20Default.aspx

7.5. Reductions in the funding and provision of social care services for older adults have occurred against a backdrop of growing demand for social care among the over-65s, as the population ages. A growing number of older people have to use their own resources to support themselves or go without care, as a result of cuts in spending and a subsequent fall in the number of people eligible for, or in receipt of, publicly funded support.

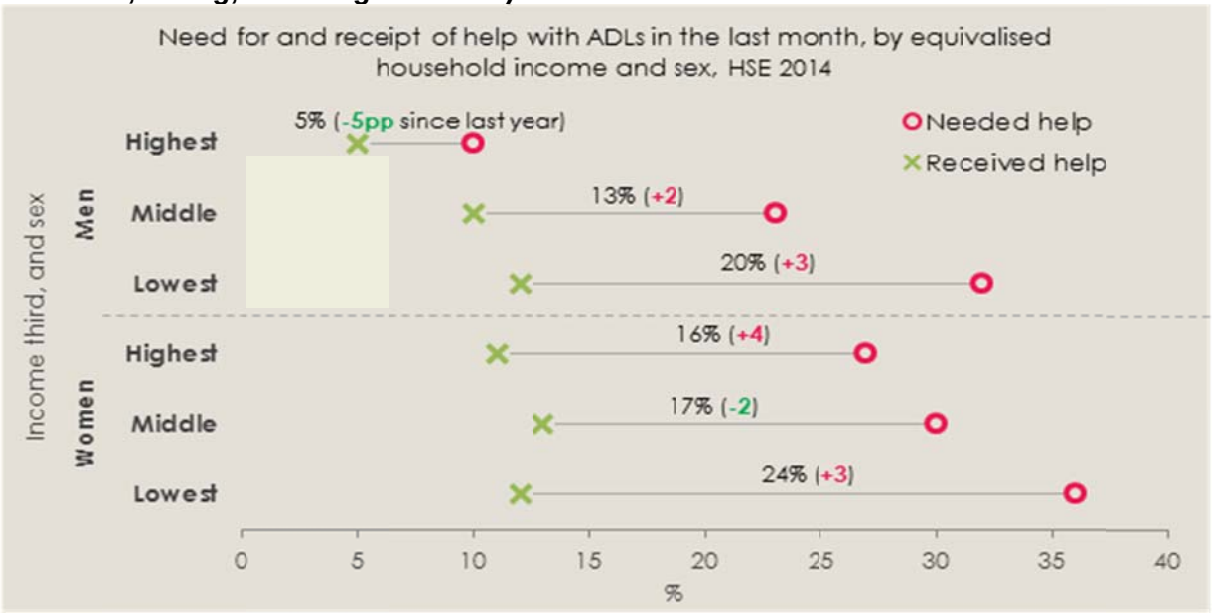
7.6. Research suggests that the level of unmet need varies widely across the different types of help needed, but overall a third of women and a fifth of men over the age of 65 report having unmet needs for some activities of daily living (ADLs). According to the Health Survey for England 2014, older people on lower incomes are less likely than those on middle or high incomes to receive support for everyday activities such as getting in or out of bed, eating, washing and taking medicines, despite needing it - as described in Figure 5. According to the 2011 national census, there was also a 2% rise between 2001 and 2011 in the number of respondents reporting that they cared for people for more than 20 hours a week[2].

7.7. The impact of these budget reductions on the health and wellbeing of older people (and their carers) is not clear. Comprehensive measurement of older users' and carers' perceptions of social care services has been put in place as part of the Adult Social Care Outcomes Framework. However, the framework only covers those who receive publicly-funded care and so the growing numbers of those who are not eligible for services are not included. It may be possible to trace the impact on users who have had their package of care reduced by the local authority, but a larger issue may be those who are reliant on their own funds, and the impact on complementary services such as the NHS[2].

7.8. The relationship between public spending on social care for older people and the demand for health services, particularly hospital care, is unclear. It is highly likely that reduced spending on social care for older adults is having a negative effect on the health and wellbeing of users and carers. But poor linkage between health and social care data at a national level means that it is currently difficult to quantify the impact. For example, although there is evidence of increased rates of emergency admissions for older age groups, it is difficult to directly attribute these to social care budget cuts rather than other factors, for example poor access to primary or community health services. There is also no way of comprehensively identifying self-funders, or informal or formal carers, in NHS or social care data, which means that the overall impact of reductions in publicly-funded social care is unknown[2].

7.9. Given the future trends in population growth and the visible constraints to local government, it is imperative that the government develops better information systems that span care providers for older people. Policymakers need a clear understanding of the relationship between social care and the wellbeing and health of older people, and the impact that cuts to social services have on other public services. At present, the difficulties faced by older people with social care needs can only be partially described and the levels of unmet need – which we expect are growing – are unknown.

Figure 5: Need for and receipt of help with Activities of Daily Living (for instance getting in or out of bed, eating, or taking medicine).



Source: Health Survey for England 2015

7.10. National data available on delayed transfers of care from hospital provides an example of the impact that reduced access to social care is having on the NHS. For example, data on delayed transfers of care identifies whether the delay was attributable to the NHS or social care or where 'both' services are jointly responsible. This is important for the financial performance of the acute sector, as our analysis found that a higher number of delayed transfers of care was associated with higher deficits in acute trusts - significant at a 90% confidence level[7].

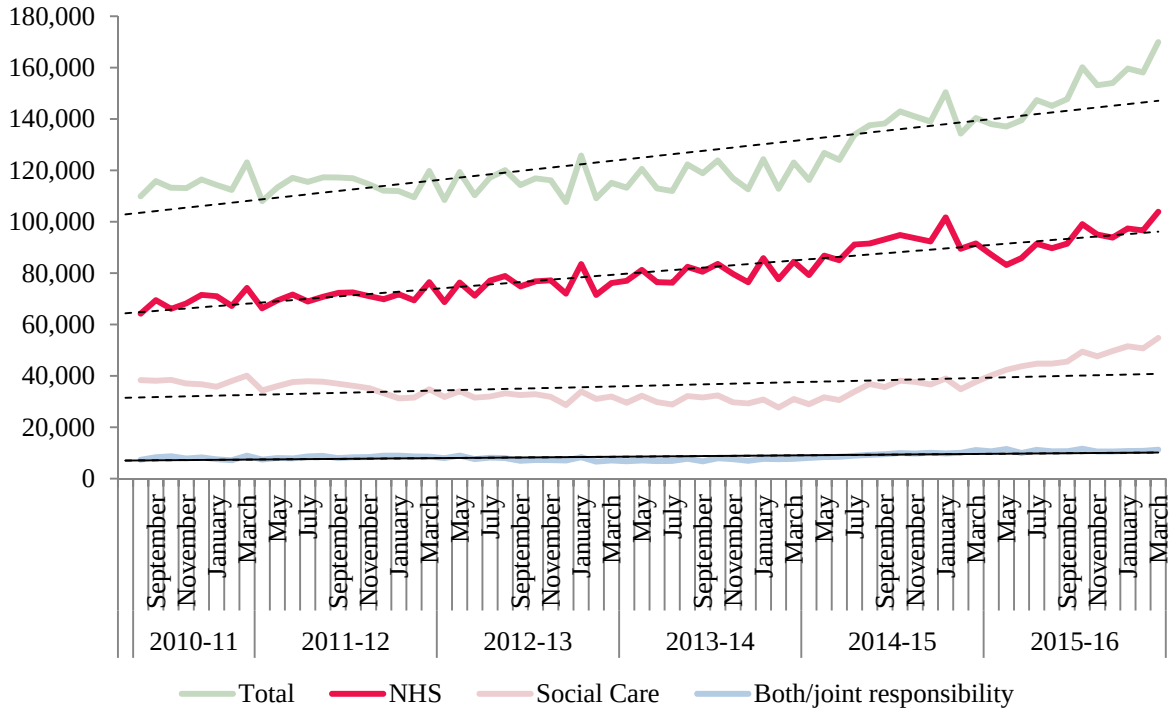
7.11. In 2015-16, the NHS was responsible for 61% of the number of patients experiencing a delay (38,723), social care was responsible for 32% (19,996) and 7% of delays were due to problems with both services (4,448).

7.12. Over the five years from 2011-12 to 2015-16, the number of patients who experienced a delay attributable to social care has grown more quickly (34%) than delays attributable to 'both' (24%) and the NHS (28%).

7.13. Figure 6 provides the total number of delayed transfers of care days for all patients in England, per month from September 2010-11 to March 2015-16, and by responsible organisation.

[7] Charlesworth, A., Lafond, S. and Roberts, A. (2016) A perfect storm: an impossible climate for NHS providers' finances? An analysis of NHS finances and factors associated with financial performance. Available at: http://www.health.org.uk/sites/health/files/APerfectStorm.pdf

Figure 6: Number of delayed transfer of care days for all patients by responsible organisation



Source: NHS England

7.14. The fastest growing reasons for delayed transfers since 2011-12 – the first full year monthly data was collected – have been 'awaiting a care package in own home' which increased by 114% and 'awaiting nursing home placement or availability' which increased by 56%. This is illustrated in Figure 7.

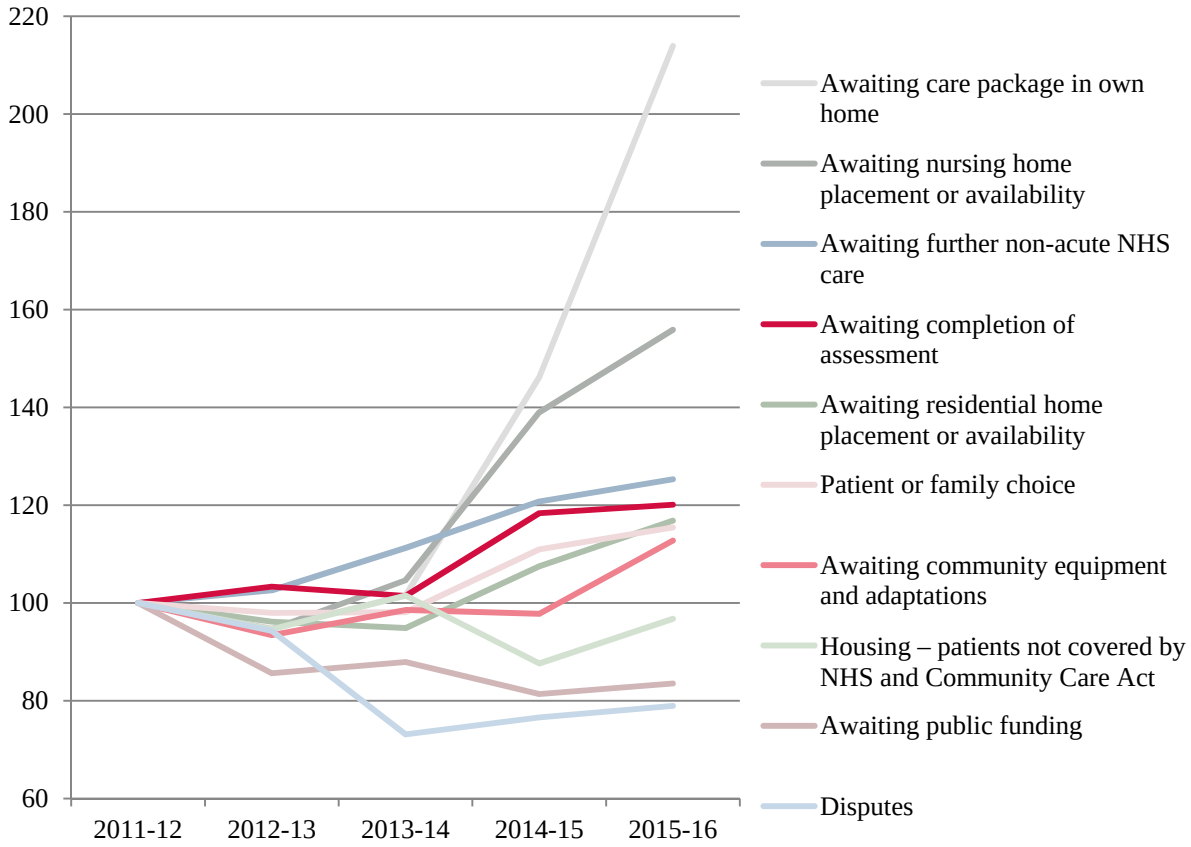
7.15. In March 2016, as shown by Figure 8, the three main reasons for the number of delays and the number of delayed days were:

- Awaiting a care package in own home (19% and 18% respectively)
- Awaiting further non-acute NHS care (18%)
- Awaiting completion of assessments (17% and 16% respectively)

7.16. While this data provides a picture of the scale of the problem of delayed transfers of care in England, it does not provide much of an insight into the specific causes and consequences of the delays. Also, much of the data is subjective and open to interpretation and is therefore fairly crude.

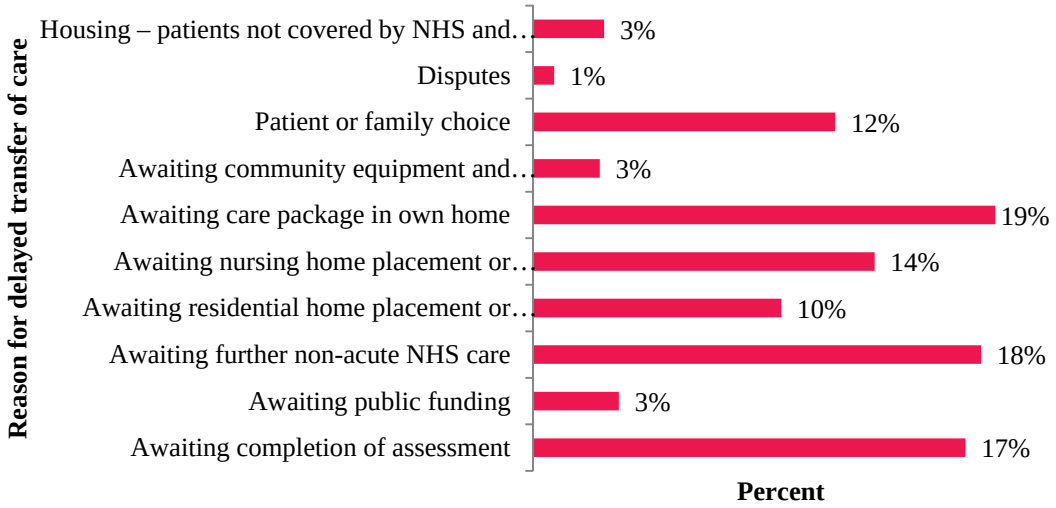
7.17. Further investigation of the processes involved and problems encountered by NHS and social care organisations when preparing patients for hospital discharge – particularly those relating to the three main and two fastest growing reasons for delays highlighted in Figures 7 and 8 – should be investigated. This will help provide a richer picture of the situation as well as highlight potential solutions.

Figure 7: Changes in reasons for patients experiencing delayed transfer of care from 2011-12 to 2015-16



Source: NHS England

Figure 8: Reasons for the number of patients delayed (March 2016)



Source: NHS England

8. Examples and lessons from Health Foundation projects

The Health Foundation has a long history of funding projects that help teams working in health and social care to develop and evaluate innovative ideas that improve the quality of care, and then where possible to scale-up and spread these across both sectors. In the following section, we have provided two examples of Health Foundation projects where NHS services, working together with social care, have developed innovative ways of improving the quality of care provided to older people.

These include projects to:

- improve the discharge of frail older patients at Sheffield Teaching Hospital NHS Foundation Trust
- implement multi-disciplinary reviews of medication in nursing homes at Northumbria Healthcare NHS Foundation Trust

Please note that in all cases the data is self-reported and has not been subject to an independent evaluation.

Improving discharge of frail older patients at Sheffield Teaching Hospital NHS Foundation Trust

Overview

As part of its involvement in the Health Foundation's Flow Cost Quality programme, Sheffield Teaching Hospital NHS Foundation Trust tested an innovative discharge process, where patients leave hospital as soon as they are medically fit to have their support needs assessed at home. This 'discharge-to-assess' scheme emerged iteratively after an extended period of system diagnosis and data analysis. The trust had to invest significant time in building the will for change among staff and it only became possible to successfully implement the approach once the trust had become integrated with community care. Previously frail older patients who were clinically well, but would have found it difficult to manage at home, were usually kept in hospital for an assessment of their intermediate health and social care needs. Patients were only discharged when this assessment had been carried out and an appropriate package of home-based care was arranged for them. In many cases, patients underwent multiple assessments over the course of several days or weeks by a range of community and social care professionals.

Approach

Sheffield's project team worked closely with stakeholders involved in each step of the assessment pathway to redesign the process and ensure that appropriate support packages could be made available in the community as soon as they were needed. As an integrated provider, the trust was able to call on its own community-based care teams to give immediate support to patients at home once they were medically ready to be discharged.

Results

The first ward to fully implement the discharge-to-assess model in 2013 reduced the average length of patient stay by seven days. The process has spread and is now implemented across the entire hospital system in Sheffield. Over the last year 10,000 patients have been transferred out of the hospital into a service now called 'active recovery', which is a health and social care collaborative aimed at ensuring that patients' needs are met and addressed in real time. This has allowed a reduction in the time taken to discharge patients for assessment at home following the completion of their medical treatment from over five days to just over 24 hours.

For projects such as this to work, there have to be good relationships between NHS and social care providers as well as commissioners. Joint ownership of the problem and solution by all those involved is essential and is supported by wider research. For example, recent research on quality improvement projects focusing on transitions between care settings emphasised the importance of gaining a shared view of the problem between those involved[8]. Further information about this project and the lessons learnt are available in a report published on our website[9].

Multi-disciplinary reviews of medication in nursing homes at Northumbria Healthcare NHS Foundation Trust

This project with Northumbria Healthcare aimed to reduce the amount of medicines prescribed unnecessarily to older patients in care homes and to involve patients, and their families and carers, in decisions about prescribing and deprescribing.

Approach
The review process involved examining primary care, care home and secondary care notes to ascertain whether medications were safe, currently performing a function and appropriate given the patient's co-morbidities, and also to identify any additional medications patients should be taking.

Medication reviews were conducted by clinical pharmacists, with the findings discussed by multidisciplinary teams which included care nurses and GPs as well as patients, families and carers where this was possible. The project involved 422 reviews across 20 care homes.

Results
There were 1,346 interventions made during the project, most of which involved stopping medicines. An average of 1.7 medicines were stopped for every resident reviewed, leaving residents with a more appropriate suite of medications for their condition(s). These were mainly due to the residents requesting the stop or because the medicine was no longer necessary. The intervention delivered an annual net saving of £77,703 or £184 per person reviewed. For every £1 invested in the intervention, £2.38 could be released from the medicines budget.

For further information:
Lewis Pickett
Public Affairs Officer
020 7257 8017
lewis.pickett@health.org.uk
www.health.org.uk

[8] Sutton, E., Dixon-Woods, M. and Tarrant, C. (2016) Ethnographic process evaluation of a quality improvement project to improve transitions of care for older people. *British Medical Journal*. Available at: http://bmjopen.bmj.com/content/6/8/e010988.full
[9] The Health Foundation (2013) Improving Patient Flow: How two trusts focused on flow to improve the quality of care and use available capacity effectively. Learning Report April 2013. Available at: http://www.health.org.uk/sites/health/files/ImprovingPatientFlow_fullversion.pdf