

Mr Huw Yardley, Committee Clerk
Health Committee
House of Commons
London
SW1A 0AA

Dear Mr Yardley,

Impact of the Comprehensive Spending Review on health and social care

Thank you for the opportunity to submit evidence to the above inquiry which I have the pleasure to do on behalf of United Kingdom Homecare Association (UKHCA), which is the professional association for providers of care at home.

Our response concentrates on five of the points of interest expressed by the committee: the distribution of funding across the Spending Review period; achieving service transformation; the impact of deficits across the sector; implications for quality and access to services; and the impact of the Spending Review on the integration of health and social care.

Our key concerns, described in greater detail in this submission are:

- The homecare sector will continue to run at a substantial deficit throughout the Spending Review period;
- This deficit will exacerbate market instability, and potentially lead to large scale market exit and/or significant provider failure;
- Capacity to meet demand for services in the homecare sector is diminishing, this is continuing to have a negative impact on the NHS, in the form of rapidly increasing delayed discharges from hospital;
- The introduction of the National Living Wage adds significant costs to the homecare sector, but has not been matched by an increase in the rates paid by local councils; and

- The distribution of funding nationally will cause inequalities in expenditure on homecare services according to the relative deprivation of localities.

We have detailed these concerns at greater length in this submission. If you have any further questions arising from points made in this document please do not hesitate to contact us.

Yours sincerely,

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1. The distribution of funding for health and social care across the spending review period

1. Our primary concern in regards to the distribution of funding allocations over the spending review period is the Treasury's decision to backload all funding increases for adult social care.

The Better Care Fund

2. The Chancellor's announcement that an additional £1.5 billion would be allocated to the Better Care Fund (BCF) was welcome, however the fact that it is to be introduced incrementally over the Spending Review period will do little to ease the ongoing funding crisis in adult social care. It is our understanding that the BCF will be introduced in the following increments:

- In 2016/17 the BCF will receive an additional £0;
- In 2017/18 the BCF will receive an additional £100 million;
- In 2018/19 the BCF will receive an additional £700 million; and
- In 2019/20 the BCF will receive an additional £1.5 billion.

3. We have calculated that over the financial year 2016/17 the homecare sector alone will run at a deficit of £753 million.¹
4. The Resolution Foundation has found that the introduction of the National Living Wage in April 2016 will increase the wage bill in the homecare sector by £800 million in the financial year 2016/17 alone.²
5. Previous research undertaken by UKHCA found that the average price paid for homecare by local authorities in the UK is £13.66 per hour.³
6. This stands in stark contrast to our externally verified,⁴ recommended minimum price for care of £16.16 per hour, which will rise to £16.70 per hour in April 2016 when the national living wage is introduced.⁵

¹ UKHCA, *Submission to the Treasury*: <http://www.ukhca.co.uk/downloads.aspx?ID=476>

² Resolution Foundation, *Care to Pay?*: <http://www.resolutionfoundation.org/wp-content/uploads/2015/11/Social-care-NLW.pdf>

³ UKHCA, *The Homecare*: <http://www.ukhca.co.uk/downloads.aspx?ID=458>

⁴ Bosanquet, N & Haldenby, A. *Value and Strategy for Homecare*: <http://www.ukhca.co.uk/downloads.aspx?ID=492>

⁵ UKHCA, *A Minimum Price for Homecare*: <http://www.ukhca.co.uk/downloads.aspx?ID=434>

7. While the King's Fund has calculated that the adult social care sector as a whole will run at a deficit between £2 billion and £2.7 billion by 2019/20 dependent upon the efficacy of the 2% council tax precept.⁶
8. To backload funding, which is quantitatively insufficient, to remedy the financial deficit across the adult social care sector, at a time of acute financial crisis will do nothing to ease the current instability within the sector and within the homecare market.⁷

2% Adult Social Care Council Tax Precept

9. The Chancellor's announcement that local authorities would be awarded greater autonomy in the form of new powers ring fence a part of their council tax revenue to fund adult social care was welcomed with a degree of scepticism.
10. In his statement to the House, the Chancellor stated that the council tax precept for adult social care could raise an extra £2 billion per annum by 2019/20.
11. This is a back loaded investment that is entirely at the discretion of individual local authorities. It is not substantive enough to address the present level of deficit or instability within the homecare market nationally.
12. If all councils were to implement the 2% precept in the financial year 2016/17, less than £500 million would be raised over that year. It is our view that it is unlikely that every local authority to implement a 2% increase in council tax, the actual revenue raised nationally is likely to be substantially less. Analysis published by the Local Government Chronicle found that 50% of local authorities plan to use the 2% precept.⁸
13. A best case scenario funding injection of less than £500 million in the forthcoming financial year is insufficient, when we consider that the homecare sector alone is forecast to run at a deficit of £753 million over the course of 2016/17.⁹

⁶ The King's Fund, *Spending Review Summary*: <http://www.kingsfund.org.uk/publications/articles/spending-review-health-social-care>

⁷ UKHCA, *Market Stability Survey*: <http://www.ukhca.co.uk/downloads.aspx?ID=486>

⁸ LGC,

⁹ UKHCA, *Submission to the Treasury*: <http://www.ukhca.co.uk/downloads.aspx?ID=476>

14. There are also serious concerns about the potential inequity of this measure as upper tier local authorities who rank higher in the indices of multiple deprivations will have significantly lower council tax revenue raising capacity than less deprived upper tier local authorities. This is illustrated in the case study below.

Case Study

Manchester City Council sits in the upper quartile of the indices of multiple deprivations, making it in relative terms one of the most deprived upper tier local authorities in England. In the financial year 2014/15 the city council raised **£115 million** of revenue via council tax. The city council received approximately **£784 million** in grants from central government and retained business rates. Council tax accounts for **12.8%** of Manchester City Council's total revenue.

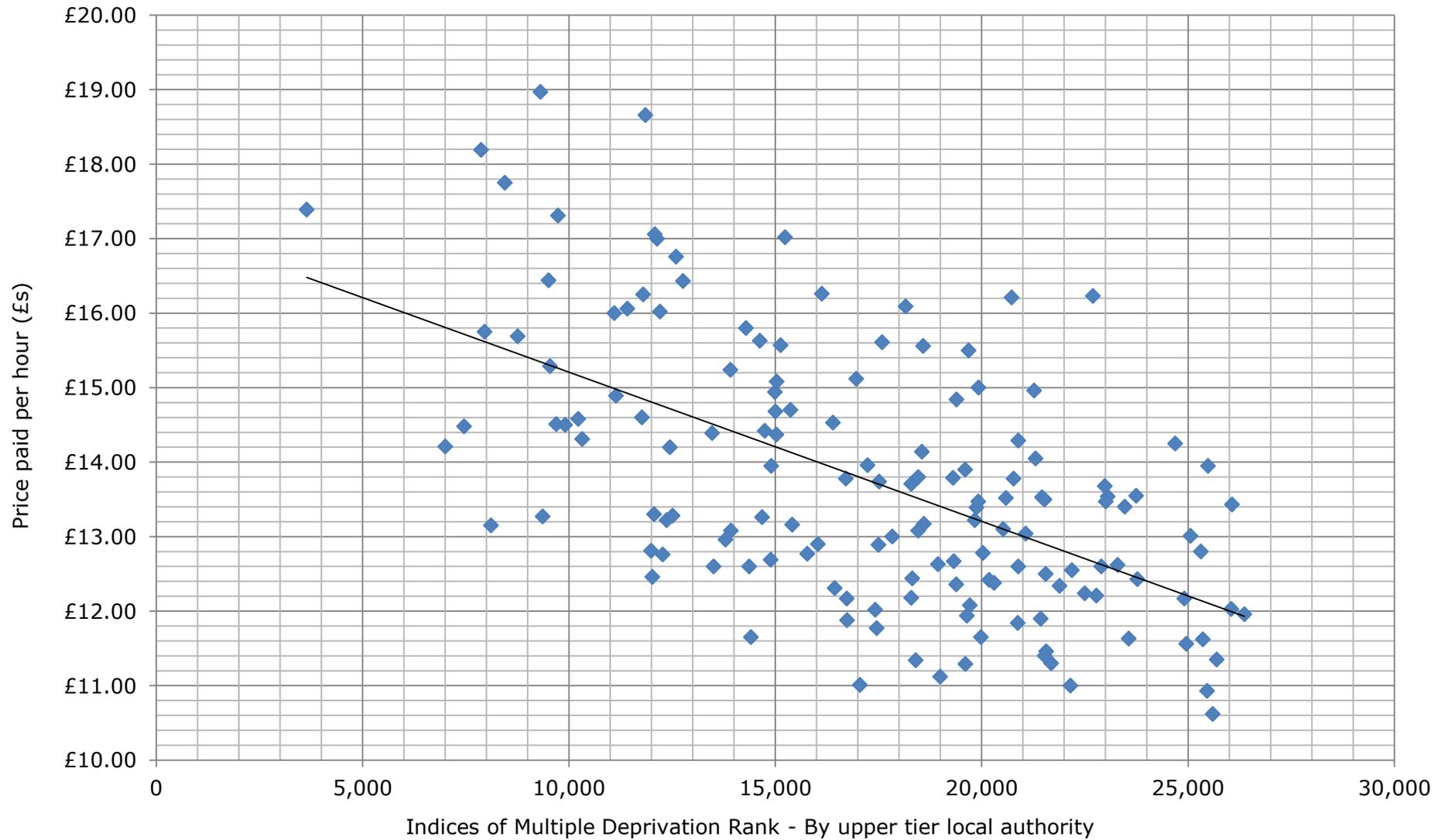
If Manchester City Council introduced the 2% adult social care council tax precept for the financial year 2016/17 their spending power would increase by **0.26%** for that financial year. This equates to an increase in spending power of **90 pence per person** in Manchester.

Oxfordshire County Council sits in the lowest quartile of the indices of multiple deprivations, making it in relative terms one of the least deprived upper tier local authorities in England. In the financial year 2014/15 the county council raised **£278 million** of revenue via council tax. The county council received approximately **£476 million** in grants from central government and retained business rates. Council tax accounts for **36.8%** of Oxfordshire County Council's total revenue.

If Oxfordshire County Council introduced the 2% adult social care council tax precept for the financial year 2016/17 their spending power would increase by **0.74%** for that financial year. This equates to an increase in spending power per capita of **£1.55 per person** in Oxfordshire.

15. We understand that the additional BCF allocation will be used in part to offset this inequality, however this in itself may act as a disincentive to implement the council tax precept for the least deprived local authorities.
16. It will also not offset existing inequalities in the price paid for homecare by local authorities according to their relative deprivation. The graph below illustrates a correlation of -0.58 between deprivation and price paid. Meaning the more deprived the local authority the lower the price paid per hour for homecare.

Price paid for an hour of homecare by local authorities against upper tier local authority Indices of Multiple Deprivation Rank



(Sources: UKHCA, The Homecare Deficit (y axis) - The English Indices of Multiple Deprivation, Upper Tier Local Authority Data (x axis))

2. Achieving service transformation set out in the Five Year Forward View (FYFV) at scale and pace through the NHS transformation fund

17. Transformative projects in the context of the FYFV are an integrationist approach to health and social care. We are concerned they are unlikely to yield savings from the outset or resolve the critical issues that confront health and social care. They are rarely an inexpensive option and there are significant resource issues in mobilising new initiatives.
18. However, we consider that incremental efficiency savings could come from improved outcomes for people who use services, changes in how hospital admissions and discharges are controlled and the deployment of new roles, such as Care Navigators and Dementia Practice Coordinators designed to introduce efficiencies.
19. The introduction of accountable care organisations, of which the Multispeciality Community Providers (MCP) within the FYFV resemble, has not been as successful as initially anticipated in other countries because of a lack of attention to implementation and execution.¹⁰
20. This carries a potential for difficulties for the service transformation schemes within the FYFV:
 - The loss of manpower in general practice and district nursing, coupled with;
 - Reductions in public spending by local authorities who commission social care, combine to create; and
 - An exceptionally fragile community social care market that the MCP's will have to contend with in their starting period. This alone could prove to be a significant hindering force holding back transformative programmes despite the elegant design of new schemes.
21. The successful development of transformational models of care will be dependent on clinical integration rather than the simple expedient of organisations or managers sharing office accommodation. This will mean

¹⁰ British Medical Journal, *The NHS five year forward view: lessons from the United States in developing new care models.*

that frontline services will experience a considerable additional burden at a time of whole sector fragility, characterised by exceptional demand-surge and capacity limitations in social care, potentially compounding existing problems with delayed discharges from hospital.¹¹

22. This gives two possible alternatives, firstly, further rationing in the volume and quality of state funded adult social care services commissioned by local authorities, or secondly, the transfer of funding from local authorities and the NHS to a single commissioning agency.
23. There are four hundred Clinical Commissioning Groups, and one hundred and fifty two local authorities with social care responsibilities plus NHS England. UKHCA believes that there is ample scope for service transformation by consolidation of commissioning in various ways that could significantly contribute to a transformation fund in both cash-release and efficiency savings.

¹¹ UKHCA, *Delayed Discharges and Homecare*: <http://www.ukhca.co.uk/downloads.aspx?ID=489>

3. Impact and management of deficits in the NHS and social care

24. UKHCA have previously calculated that at current market conditions, the homecare market will run at a deficit of £753 million over the financial year 2016/17.¹²
25. We have also calculated that the minimum price for homecare will be £16.70 per hour from April 2016 when the new National Living Wage comes into effect.¹³
26. Previous research conducted by UKHCA found that the average rate paid by the state for homecare is £13.66 per hour.¹⁴
27. Given this, we believe that the homecare sector is operating at a substantial deficit, which will grow as operating costs increase at a rate that central and local government have not matched.
28. The impact of this deficit has been acute and widespread. Key impacts have included:

Market instability

29. Market instability increases the likelihood of care providers exiting the market place or suffering business failure. This impacts upon the quality and continuity of care experienced by people who use services, and requires the council undertake a lengthy and expensive re-tendering exercise.
30. UKHCA conducted survey research among our membership on the stability of the homecare market.¹⁵ In a sample of 492 providers who deliver 888,000 hours of care per week to 85,000 people in their own homes we found that:
 - 93% of providers had faced decrease in price paid for an hour of care by their local authority in real terms over the past twelve months;
 - 50% of providers who were aware of tender opportunities from their local councils had declined to bid for one or more contract on the basis of price;

¹² UKHCA, *Submission to the Treasury*: <http://www.ukhca.co.uk/downloads.aspx?ID=476>

¹³ UKHCA, *A Minimum Price for Homecare*: <http://www.ukhca.co.uk/downloads.aspx?ID=434>

¹⁴ UKHCA, *The Homecare Deficit*: <http://www.ukhca.co.uk/downloads.aspx?ID=458>

¹⁵ UKHCA, *Market Stability Survey*: <http://www.ukhca.co.uk/downloads.aspx?ID=486>

- Over the last year 71% of respondents who traded with councils refused to take on new packages of care either 'regularly' or 'occasionally'; and
- There is strong evidence of further market instability over the coming year. 74% of respondents who trade with councils said they would reduce the amount of publically funded care they provide.

Diminishing capacity in the homecare sector

31. The financial deficit in the homecare sector and the destabilising effect it has had upon the market has in turn caused supply, or capacity, to diminish. There are two principle drivers for this:

- Constrained local authority budgets have seen eligibility thresholds rise and fewer people meet eligibility criteria.
- Homecare providers are electing to reduce the quantity of state funded care they provide, as it is uneconomic. As evidenced in our market stability survey

32. Between the financial years 2009/10 and 2013/14, 18% fewer people received state funded homecare in the UK.¹⁶

33. This is at a time when demography, particularly the rate of ageing, show that demand should be increasing. It is clear that demand and supply are at a divergence.

34. The International Longevity Centre recently published research showing that the level of unmet need has increased sharply in recent years. Their research shows that 1.86 million adults aged over 50 years have unmet care needs. This is an increase of 7% since 2008/9.¹⁷

The impact on the NHS

35. Homecare does not sit in isolation within the health and social care economy. The reduced capacity within the state funded homecare sector has

¹⁶ UKHCA *An Overview of the Domiciliary Care Market in the UK*:

<http://www.ukhca.co.uk/downloads.aspx?ID=109>

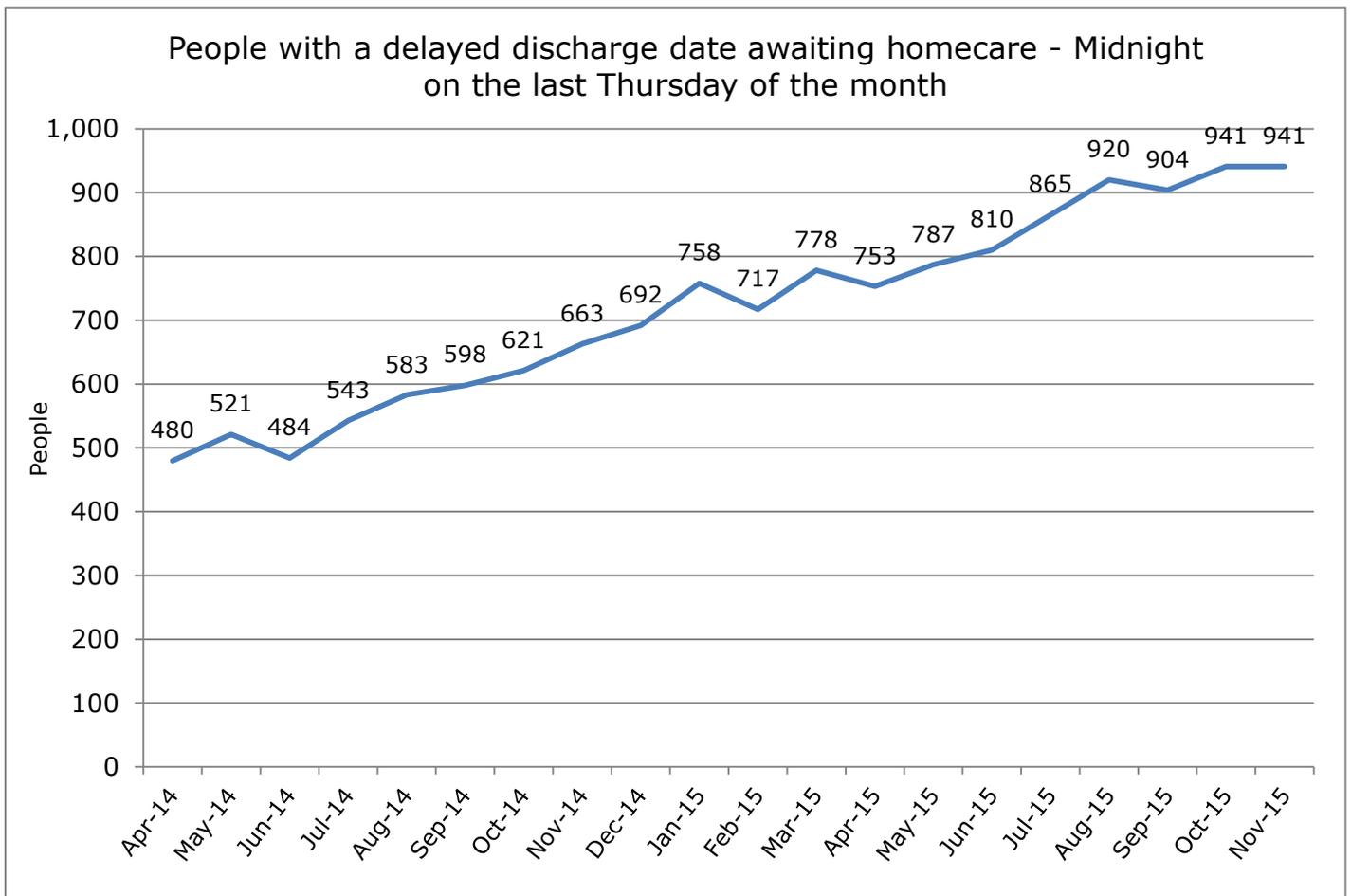
¹⁷ ILC, *The End of Formal Adult Social Care?*:

http://www.ilcuk.org.uk/index.php/publications/publication_details/the_end_of_formal_adult_social_care

exacerbated inefficiencies within the NHS, namely in the form of delayed transfers of care from acute hospital settings into the community.

36. On the last Thursday of November 2015 there were 941 people experiencing a delayed transfer of care from hospital because they were awaiting a package of homecare. This represents a 110.5% increase on the same figure from February 2014.¹⁸

37. The persistent increase in people awaiting discharge from hospital while awaiting a package of homecare is illustrated on the graph below.



¹⁸ NHS England, *Delayed Transfers of Care Data 2015/16*: <https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2015-16/>

38. NHS England record that over the month of November 2015 a total of 26,794 bed days were lost due to people experiencing a delayed discharge while awaiting a package of homecare.¹⁹
39. This represents a monthly expenditure on delayed discharges due to people awaiting a package of care at home was £8.1 million in November 2015.²⁰ We forecast that the NHS will spend approximately £97.4 million on people experiencing a delayed discharge date while awaiting a package of homecare.
40. We believe that one of the principle causes for the observed rapid growth is the diminishing capacity in the homecare market described earlier in this section.

¹⁹ NHS England, *Delayed Transfers of Care Data 2015/16*:
<https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2015-16/>

²⁰ NHS England record a unit cost for delayed transfer of care of £303 per person per day.

4. Social care funding, including implications for quality and access to services, provider exit, funding mechanisms, increasing costs and Care Act provisions

41. We have previously detailed our concerns in this response that the additional funding offered for social care provision in the Spending Review is insufficient.
42. The Chancellor stated that the adult social care sector would receive an additional £3.5 billion per annum by the end of the Spending Review period. This funding is back loaded and quantitatively insufficient. We have covered this issue in greater detail earlier in this document.

Operating costs

43. We noted earlier that the homecare sector is forecast to run at a deficit of £753 million over the financial year 2016/17. This figure has increased from £513 million for the current financial year.²¹ This increase is due primarily to increasing operating costs for homecare providers.
44. From the 1st April 2016 UKHCA's calculated minimum price for homecare will increase to £16.70 per hour due to the introduction of the National Living Wage.²²
45. Our minimum price for homecare document shows that the wage cost of hiring a careworker makes up 71% of the total hourly operating cost for a homecare provider.
46. A full breakdown of how the wage costs of our minimum price are calculated is displayed below.
47. The remainder is made up of running costs and a 3% surplus.

²¹ UKHCA, *Submission to the Treasury*: <http://www.ukhca.co.uk/downloads.aspx?ID=476>

²² UKHCA, *A Minimum Price for Homecare*: <http://www.ukhca.co.uk/downloads.aspx?ID=434>

Item	Assumption		From October 2014	From April 2016
Workers' contact time:		See note ²³	£6.50	£7.13
Travel time:	11.4	minutes per hour of contact time	£1.24	£1.35
Gross pay:			£7.74	£8.48
National Insurance:	9.50%	of gross pay	£0.73	£0.81
Holiday pay:	12.07%	of gross pay	£0.93	£1.02
Training time:	1.73%	of gross pay	£0.13	£0.15
Pensions:	1%	of gross pay	£0.08	£0.08
On-costs:			£1.88	£2.06
Total wage costs:			£9.61	£10.54
Mileage costs:	£0.35	per mile at 4 miles/hour of care	£1.40	£1.40
Total wage costs, including mileage			£11.01	£11.94

²³ In October 2015: Assume that 100% workers receive NMW of £6.70/hour.

From April 2016: Assume that 13.7% of workers are <25 years and continue to receive £6.70/hr and that 86.3% are entitled to the new NLW of £7.20/hour

5. Impact of the spending review on the integration of health and social care

48. It has been estimated that by 2020 there will be a £30 billion funding deficit that is unlikely to be closed by the new care models described in the FYFV or Lord Carter of Coles' review of NHS productivity, even taking into account the additional £8 billion pledge from Government.
49. The financial pressure is being registered in all sectors of the NHS, with Monitor projecting a deficit of more than £1 billion for the NHS over the financial year 2015/16.
50. The risks to achieving a more efficient NHS focus on the impact of social care financial constraints and the impact of delayed discharges coupled with increasing demand. We note that in 2014/15 delayed discharges cost the NHS £1.15 billion at a unit cost of £303 per person per day.²⁴
51. Against this financial backdrop it is essential that there are mechanisms in place to run a new care model at the in parallel with existing services before they are decommissioned. This leads to UKHCA's underlying concerns about the potential effectiveness of the FYFV if there is no fully funded transitional provision and fully costed mobilisation plans.
52. We are concerned that the value of the FYFV could be adversely affected by developing transformative models of care rather than addressing the foundational issues within health and social care. This is because we do not see existing inefficiencies within the NHS being forcefully addressed and we are concerned that this could undermine the drive towards broader systems and systemic integration.
53. UKHCA has concerns that the hybridisation model, in effect, bolts together existing elements of some care services, to create a reconfiguration rather than fundamental re-design. Our view is that realistic transformation is a strategic disposition rather than a tactical repositioning of existing assets.
54. This leaves us with the existing map of NHS facilities and services with superimposed New Models of Care that do not address the system-wide constraints that are holding back overall integration of health and social care across all functional boundaries. This is because local authority contracting for social care remains entirely disconnected from all other health and social

²⁴ NHS Reference Costs 2014/15. Available at: <https://www.gov.uk/government/publications/nhs-reference-costs-2014-to-2015>

care systems and care pathways. The impact of increased demand, delayed discharges and inappropriate hospital admissions reverberate throughout the health and social care sector because of the way social care is commissioned without due regard to broader, systemic considerations.

55. We believe that there are sufficient funds available to develop an effective, integrated health and social care system. We consider that the realisation of the FYFV is adversely affected by the retention of NHS legacy services, such as small inefficient general hospitals, at the expense of fully funded purposeful integration that would prevent the further dissipation of scarce resources in ways that cannot possibly add value to the health and well-being of the nation.