RADIX

VOLUME TWO

PROFESSOR STEPHEN K SMITH

What social care is and how it can be fixed.

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What social care is and how it can be fixed.

RADIX

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SUMMARY

Adult social care and NHS services within the Integrated Care Systems can be merged immediately.

The merger is not a takeover of the NHS by local authorities, nor vice versa, but a new integrated, patient-centred service: managing the cultural challenges of a 'merger of equals' is a key task.

The funding of social care needs a sustainable solution: cash injection in the short term and an hypothecated tax in the medium term.

Merging adult social care and the NHS locally will trigger an opportunity for a more thoroughgoing reform and modernisation of local government.

What is social care, and what is the 'crisis'?

Unlike healthcare (the NHS), social care can mean different things to different people. That could range from social welfare (unemployment benefit or housing benefit) through charities such as Age Concern to a situation where a wife cares for her ailing husband. In its use in this book, it is none of these.

It is a well-defined set of services for vulnerable people. This book will describe these, and will outline the 'crisis' that this sector is experiencing due to severe government cuts over the last ten years. Despite real suffering for the most vulnerable in our society, politicians take little notice of it, and the public holds them to little account for the failure.

The book concludes by asking why this is the case.

The protection of vulnerable children and adults.

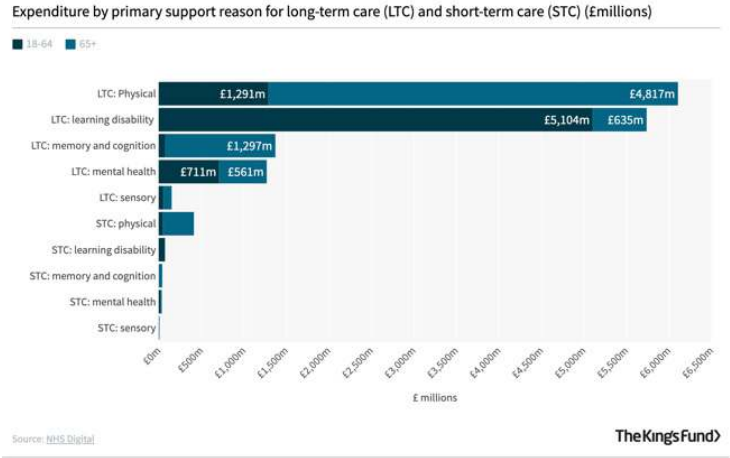
SECTION 1

Social care in England is the provision of social work, personal care, protection, or social support to children and adults who are 'at risk'.

Social care in England is the provision of social work, personal care, protection, or social support to children and adults who are 'at risk'. There is some overlap in children's and adult services, mostly in treating mental health issues, but they are mostly distinct. Children's services mainly comprise protection of vulnerable children which, in many cases, means taking them into care or implementing 'safeguarding measures'.

Children's services also include preventative family support and child protection services, child placement, fostering, adoption, working with young offenders, children and young people who have learning or physical disabilities, or who are homeless, as well as support for families and carers. A lot of the work is legal, acquiring court orders to remove children from abusive households. About £9 billion a year is spent by councils on children's social care.[1]

Council spending on adult social care is about £23.3 billion a year.[2] Most of this money is spent on long-term care, split almost equally between working-age adults and older people. The spending on working age adults is partly to care for younger people with physical disabilities, but is mostly spent on care homes for people with mental health issues, especially learning disabilities.



The remainder is spent on a broad range of services, including short-term care, support for carers, information and prevention, assistive technology, support for social isolation, and the costs of commissioning and service delivery. The breakdown is shown in the chart above:[3]

Nearly £6 billion is spent on elderly people in care homes, with needs arising from illness, disability, old age or poverty. The main legal definitions flow from the National Health Service and Community Care Act 1990. That provision has one or more of the following aims:

- *To protect people who use care services from abuse or neglect,*
- *To prevent deterioration of, or promote, physical or mental health,*
- *To promote independence and social inclusion,*
- *To improve opportunities and life chances, to strengthen families, and*
- *To protect human rights in relation to people's social needs.*

There are about 400,000 frail elderly people in care homes, and a slightly lower number receive some care at home. About half of those in care homes and 70 per cent of people receiving home care are paid for by local authorities. The rest are paid for by themselves or their families.

Private (family) spending on social care services – care homes and home care – amounts to about a further £12 billion a year. NHS services are free-at-the-point-of-care – and paid for by central government from general taxation.

Social care is not free. A family's income is assessed and people only qualify for local authority funding when total net worth falls below £14,250 (including their home). Clearly these people are not affluent. The physical criteria to assess whether or not a person qualifies for this type of care has become increasingly strict over the last ten years. In order to qualify, people need to be assessed with extreme physical or mental health problems. These are people who are at the extreme end of being unable to look after themselves. Legislation planned to begin in 2023 will change these thresholds, as described in a later section, but it will have very little impact on the care that the poorest in our society receive.

A further 100,000 younger people with learning disabilities, physical disabilities or mental health problems are using publicly funded home care[4], costing about £6 billion.

What is the crisis in social care?

SECTION 2

The domiciliary, or home care sector has been in crisis since the coalition government started cutting local authority funding in 2010. This has meant that more people have had to start paying for care services, but for those who cannot afford to pay themselves, they are often denied care even if their net worth falls to below £14,250 as a result of stricter assessment criteria.

The level of expenditure in 2020 was below the 2010/11 level, and it does not reflect the increases in population and levels of demand in the last ten years. Per capita, needs-based spending, then, has fallen dramatically.

Nor have cuts in social care been evenly distributed: between 2010/11 and 2017/18, the 30 councils with the highest levels of deprivation cut services by 17 per cent per person, compared to cuts of 3 per cent per person in the 30 least-deprived areas.[5]

Whether by design or accident, the burden of the social care crisis is falling on the poorest in our society, and geographically, that often means the north of England.

Commissioning and delivering home care of the highest quality, connected as closely as possible with health and housing services, and with the best outcomes and greatest efficiency, should be a significant objective for our health and social care system. Yet the future of home care is uncertain and the market is fragile.

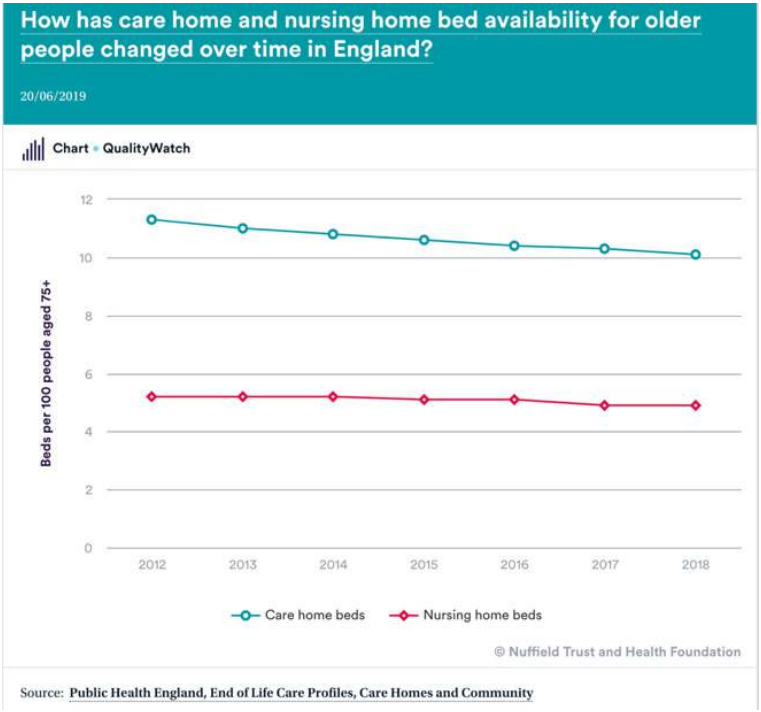
A survey of directors of adult social services in 2017 – the most recent survey available – found that 39 per cent had experienced home care providers ceasing to trade in the previous six months and 37 per cent had experienced contracts being handed back.[6]

In the past three years, three of the biggest national providers of home care – Saga, Care UK and Housing and Care 21 – have withdrawn from the publicly funded home care market, while two others (Mears and Mitie) reported losses in their homecare divisions.

Mitie subsequently sold its homecare business for £2.[7] In December 2018, Allied Healthcare, which provided domiciliary care for 13,500 vulnerable elderly people, went into liquidation and was bought at a knockdown price.

Home care agencies employ around 700,000 people – similar to the numbers employed in residential care – of whom the vast majority do 'direct care' as care workers. These numbers are likely to need to increase significantly in the coming years to cater for growing need, yet the care sector struggles to recruit even the number of staff it currently needs (there are around 110,000 vacancies at any one time).

Over half of home care workers are employed on zero-hours contracts and turnover in both care homes and home care is running at over 40 per cent. The work is hard – cleaning faeces and vomit regularly during a typical day, and the pay is poor at about £7.89 an hour, less than a checkout operator at Tesco earns.[8]



AT THE SAME TIME THAT HOMECARE IS UNDER PRESSURE, THE CARE HOME SECTOR IS CONTRACTING ALARMINGLY AS FEE RATES AND OCCUPANCY DECLINE:

> *'Between 2012 and 2018, the overall number of beds in care homes (nursing and residential) per 100 people aged 75 and over declined from 11.3 to 10.1 – a 10 per cent decrease. Likewise, the number of nursing home beds per 100 people aged 75 and over fell from 5.2 to 4.9 – a 7 per cent decrease.'*[9]

A RECENT NEWSPAPER ARTICLE EXPLAINED:

> *'Britain's care homes are facing a crisis [due to] dramatic cuts to social care funding….The population who live in care homes are extremely vulnerable yet the government is funding this vital service to the tune of about £2.50 an hour [per resident]. This is not sustainable and we will see some providers in severe financial difficulties in the coming years unless this issue is addressed.'*[10]

THE SITUATION IS GETTING WORSE:

> *'The UK is running out of care home places and soon there will not be enough to look after the growing number of vulnerable older people needing specialist care….More than 100 care home operators collapsed in 2018, taking the total over five years to more than 400 and sparking warnings that patients in homes that close down could be left with nowhere to go but hospitals.'*[11]

These declines come at a time, with the ageing population, of increasing need. Acute hospitals are not an appropriate setting for frail, older people unless there is an acute clinical need. A 10 per cent decrease on a stock of about 450,000 beds is 45,000 – set against a total NHS acute bed provision of about 100,000. These 45,000 residents are very ill and require a bed and if one does not exist in the community, then a hospital bed is the only other option. There is little wonder that the acute hospitals are suffering such extreme pressure.

The image that some people have of care homes is afternoon tea and scones, and happy, elderly people having a singalong. For those with relatives in care homes, and for those in the sector, this is very far from the truth. Most elderly – and, indeed, younger – people in care homes are very ill. The elderly residents are people with long-term health conditions, and they will die, on average, after a little more than two years in the care home, having inevitably deteriorated markedly in the last years of their lives.

THEY WILL BE SEEN BY GPS AND OTHER HEALTHCARE PROFESSIONALS REGULARLY AND WILL ATTEND HOSPITAL AS OFTEN AS EVERY MONTH. LIFE IN A MODERN CARE HOME IS WELL DESCRIBED IN THIS PIECE:

> *'Lizzie Hancock has run her family-owned Fulford nursing home in York for 25 years, during which time it has changed from a cosy retirement pad into a serious operation with lifts, hoists and residents with myriad needs. "It's no longer Susan doing a jigsaw puzzle and baking a cake for Lily and May, it's full-on nursing with catheters, drips and 24-hour care," Ms Hancock says. Fulford has 39 staff to look after the 28 residents, with eight from Nepal. "They are amazingly hard working and devoted to the residents," Ms Hancock says. But her wage bill has risen in the past decade from £17,000 a month to £12,000 a week after the minimum wage, new pension scheme and training is added in. Ms Hancock works from a shed in the garden, hardly pays family members, uses her father as her babysitter and rarely takes a holiday, but the only way she has been able to survive is to take more self-funded residents as the local authority has cut the amount it is prepared to fund. Now, with the living wage being introduced, she will need to stretch her budget even further.*
>
> *'Ten years ago more than three quarters of residents were paid for by the local authority; now more than three quarters are self-funded. A single room that cost £420 a week now costs a self-funder £750 to £900. Fulford has a waiting list and is very popular locally but, if it is going to survive, Ms Hancock knows that she will have to increase the fees further. "I feel really guilty . . . but the only way we can keep going is if new residents fund themselves," she says. "I love my elderly residents but I feel increasingly that we can only take the best-off as we are haemorrhaging money with a constant need for more sophisticated equipment as residents live longer and become more frail.*

"I would be afraid of getting old if I didn't have any money now as soon it will be almost impossible to find a suitable care home unless you win the lottery. Just when you are at your most vulnerable and often alone there is hardly any choice any more. You either pay vast amounts or you are thrown at the mercy of some councils. It's like a return to the poor houses in the Victorian era."' [12]

The distinction between what is free healthcare and paid-for social care is increasingly arbitrary. The unfairness is most obvious in the case of dementia. This illness was, many years ago, thought of as 'just old age', a touch of senility. It is now known that dementia has a very clear physical pathology. Alzheimer's, which is the major cause of dementia, is characterised by damage to the brain arising from a variety of causes, one of which is the deposition of amyloid and tau in the brain. Altering amyloid levels may be an effective target for therapy and Aduhelm is the first medication licensed for use in its management.

The second most common cause of dementia is aneurisms as a direct result of a stroke. It is also becoming clearer that deprivation and the associated poor lifestyle choices, such as a poor diet and smoking, are associated with a greater chance of contracting dementia. What little wealth poorer people might start with is quickly denuded by the arbitrary, means-tested social care system.

There is an ideology that a person's own home is always the best place for them, and that the decline in care home beds is a good thing. This is often not true – it's a middle-class, healthy person's perspective. People should be in the most appropriate and safest setting given their condition. This ideology is consigning too many people to lonely lives and early deaths.

The recent research on loneliness shows that a care home is a more appropriate environment for many older people – even if they are relatively fit and not living with dementia. Of course, loneliness can be alleviated by organising more social encounters for people living alone in their own home. But care homes – especially if they are well-funded and well-resourced – are going to play an ever greater part in keeping people safe and healthy as our population ages.

'Loneliness can increase the risk of heart disease by a third and must be treated as seriously as obesity and smoking…. A million older people in Britain say that they are chronically lonely, a figure expected to increase by 600,000 within two decades, and isolation has previously been linked to dementia and early death. One study found that lonely people were 50 per cent more likely to die early, a similar risk to smoking and drinking.'[13]

AND AGAIN:

'Loneliness can rewrite people's immune systems, leaving them more vulnerable to illness and early death…. The sense of extreme isolation may also trigger a biochemical vicious circle that leaves the patient feeling even lonelier than they did before. These changes could affect millions: more than half of the over-75s in England live alone, while an estimated five million pensioners have only their television for dependable company….lonely people are more disease-prone.'[14]

The problem of caring for the frail elderly and those with mental illness is not going away – indeed, it is growing year on year.

The numbers of disabled older people, defined as those unable to perform at least one instrumental activity of daily living (IADL)[i] or having difficulty with performing or inability to perform without help at least one activity of daily living (ADL), will rise by 67 per cent between now and 2040 and by 116 per cent between now and 2070, from 3.5 million to 5.9 million in 2040 and 7.6 million in 2070.

The number of older people with more severe disability, that is, unable to perform without help – or at all – one or more ADL tasks, will increase by 69 per cent between now and 2040 and 124 per cent between now and 2070, from 1.7 million in 2015 to 3 million in 2040 and 3.9 million in 2070.15 In simple terms, given the current state of provision, this would imply a rise in the public funding required of £6.3 billion by 2040.ii There are, currently, 1.4 million frail and infirm people who are not getting the help they need.[16]

i Instrumental activities of daily living (IADL) are those activities that allow an individual to live independently in a community. Although not necessary for functional living, the ability to perform IADLs can significantly improve the quality of life. The major domains of IADLs include cooking, cleaning, transportation, laundry, and managing finances. IADLs are commonly assessed by occupational therapists in the setting of rehab to determine the level of an individual's need for assistance and cognitive function. IADLs are different from basic activities of daily living (ADLs). The major domains of ADLs are feeding, dressing, bathing, and walking. In contrast with IADLs, ADLs are necessary for basic functional living. Deficits in performing ADLs may indicate the need for home healthcare or placement in a skilled nursing facility.

ii 70% of 400 + 50% of 400 = 480/800 rising by 70% and current expenditure about £9 billion = so now 816,000 people need it and so it's 70% of £9 billon = £6.3billion

Under the Care Act 2014, local authorities have a statutory duty to 'shape' this market – to make sure that there are sufficient services of a sufficiently high quality to meet needs. An indication that this is not the case comes from the increasing wait for homecare packages for people ready to leave NHS hospitals.

This is now the single biggest reason for delayed discharge from hospital, rising from 12,777 bed days lost in August 2010 to 33,520 in March 2018.[17] How councils respond to these differing local circumstances is at least in part driven by the state of their budgets.

The Local Government Association (LGA) says that, by the end of this decade, English councils will have had a £16 billion reduction in government grant funding since 2010, at a time when there are increasing numbers of ageing and disabled people[18]. Councils are therefore caught in the crossfire between rising demand and reduced funding. As a consequence, control of expenditure on social care has been vital, and one key factor in this is the rate they pay to private providers for commissioned home care. Since their local situations vary significantly, in practice this means that different councils may pay very different rates.[19]

Why do politicians overlook social care?

SECTION 3

Social care, until recently, has not been high up on the politicians' agenda. And even now, reform of social care has been promised since 2016, but the long-awaited government white and green papers have been consistently delayed. Why has social care received such little attention until recently, and so little action even now?

There are at least seven possible reasons for its lowly position on the politicians' 'to do' list.

FIRST, THERE IS OFTEN SOME CONFUSION IN THE EYES OF THE PUBLIC ABOUT WHAT SOCIAL CARE ACTUALLY IS.

As explained in the introduction, some people view it as synonymous with social welfare and as an alternative to another often poorly understood (and sometimes amorphous) activity of social work. For some others, the term often implies informal networks of support and assistance. This confusion in the public's mind results in little pressure being put on politicians who therefore tend to view it as low priority. Recent health questions in the NatCen British Social Attitudes Survey found that 34 per cent of the public surveyed believed that adult social care is provided for free by the NHS.[20]

SECONDLY, AND RELATED TO THIS, SOCIAL CARE HAS LITTLE 'VOICE'.

Wealthier people accept that they need to pay, and the people who are suffering from declines in funding are poorer people who are often not heard above the general hubbub of society. As a sector, also, it tends to lack a clear and distinctive spokesperson, with a number of competing, underfunded industry bodies having relatively little impact on the consciousness of politicians. This contrasts with the NHS with its high profile senior managers and ministers, and sky-high prominence in the public's mind.

These two factors are beginning to change as more and more people seek care for their elderly relatives and see the work and care that goes on in care homes and home care workers, and as more people actually take on direct care responsibilities looking after elderly relatives.

The covid crisis, and the shabby way in which care home residents have been treated, has also highlighted the plight of the sector. There is some progress, too, in the sector getting some voice. Martin Green of Care England and Jane Townson of the Homecare Association have, in particular, been increasingly clear and articulate during the covid crisis.

THIRDLY, THERE IS A SENSE, AGAIN WITH SOME JUSTIFICATION, THAT SOCIAL CARE IS ABOUT OLD PEOPLE WHO ARE GOING TO DIE IN ANY CASE, AND THE NHS IS ABOUT THE LIVING WHO NEED TO BE KEPT WELL.

We go, bluntly, to care homes to die – usually dying with dementia, and in many cases having forgotten who our relatives are – whereas we go to hospitals to get well again. This rather dismissive view of the social care sector is compounded by the views of the medical profession which views care homes and home care as not even a nursing job, but more of an 'emptying bed pans' and 'making beds' occupation.

It is, of course, much more than that, but very few medics, except for GPs, spend much time in care homes, and even the GPs are sometimes reluctant to visit care homes. On top of this, geriatric medicine has always been somewhat down the medical pecking order. The problem, though, is twofold: first, we do still have a responsibility to care for the elderly and to allow them to die with dignity; and, in any case on a purely materialistic basis, the two systems are connected and the 'wellness' service of the acute hospitals is being severely undermined by the overwhelming nature of the social care crisis, and the deluge of frail elderly people arriving at A&E and being admitted to scarce hospital beds inappropriately.

A FOURTH REASON COULD BE THE BEHAVIOUR OF THE PRESS WHICH OFTEN PLAYS AN UNHELPFUL ROLE IN DEMONIZING SOCIAL CARE, ESPECIALLY CARE HOMES, FOCUSING ON THE VERY RARE INSTANCES OF POOR CARE.

The Winterbourne View scandal of 2012 was a BBC Panorama 'bestseller'. [21] Although it involved a home for young people with learning disability, many people perceived it – and still do – as applying to a care home.

FIFTHLY, THERE IS MUCH MORE POLITICAL MILEAGE IN THE NHS THAN IN SOCIAL CARE.

Politicians are eager to be photographed with their sleeves rolled up, walking round an NHS hospital with nurses and doctors in tow. The talismanic nature of the NHS is so compelling that politicians vie with each other to promise to put more money into it. It is less attractive to be filmed going round a care home, and, especially at a time of austerity, it is tempting to announce investments in the NHS and to let social care stagger on for another year. The recent announcements by the Johnson government will, as described shortly, do very little to actually fix social care.

THE SIXTH POSSIBLE REASON FOR THE GOVERNMENT'S INACTION IS BEWILDERMENT.

It would be disingenuous to suggest that politicians don't understand the system, and cannot make the link between funding cuts in social care and crisis in the NHS. More generous is the possibility that politicians don't know what levers to actually pull. A number of ex-ministers have, in conversation, confirmed their perplexity and sense of helplessness in thinking through how to engage with the local authority structure, and how to actually engineer a better system even if more money were available. This problem is not helped by unhelpful political point-scoring.

The Labour Party has been as inarticulate as the Tories in coming up with practical solutions, and the knockabout nature of modern British politics is diverting politicians from grasping the nettle.

> *'In 2010, the Tories attacked Mascara Kid Andy Burnham's ideas for funding a universal national care service through changes to inheritance tax as 'Labour's Death Tax'….Labour returned the favour in the 2017 snap general election, with the Tories' proposal slightly rebranded as a 'dementia tax', forcing Theresa May into her nowinfamous 'nothing has changed' U-turn….Social care faces a range of problems to get up the public policy and indeed general public agenda – its name is unhelpful at describing clearly what it is; it is unaspirational, being generally associated with dependency, older age and infirmity; and its non-universal, means-tested nature has unfortunate connotations of benevolence, charity and paternalism.'*[22]

THE FINAL POSSIBLE FACTOR IS POLITICAL.

The inattention to social care could be due to the Conservative view of local authorities, especially Labour councils in the north of England. The reduced funding has hit the poorest councils (mostly in the north and central London) that have lower local tax-raising potential (and therefore are more vulnerable to cuts in the roughly half of the budget supported by central government grants), and greater need in the community as more people are deprived, have unhealthy lifestyles and are more dependent on the state.

> *'Austerity cuts have fallen hardest on deprived communities in the north of England, which are enduring the highest poverty rates and weakest economies. Local authority spending has fallen nationally by half since 2010, with areas such as Liverpool, Blackburn and Barnsley facing average cuts twice that of their counterparts in the more affluent south….The five cities and towns that have suffered the biggest falls in spending over the past eight years are from the north of England: Barnsley (-40%), Liverpool (-32%), Doncaster (-31%), Wakefield (-30%) and Blackburn (-27%). The British average is -14.3 per cent.'*[23]

There is an argument that, before 2010, Labour councils were overindulged by the Labour government and had become profligate. And there is probably some truth in this. Yet the pendulum has clearly swung too far against the more disadvantaged, mostly northern councils. This might change with the Tory success in the Red Wall Labour seats in the 2019 general election.

Eventually, however, the disregard of politicians catches up with them. It was painful to hear Jeremy Hunt, Secretary of State for Health and Social Care for six years, say that he regretted not spending more on social care:

> *'Jeremy Hunt admitted last night that the government had not spent enough money on social care and was now paying the price. During a fractious debate, the foreign secretary said that "some of the cuts in social care did go too far". The admission came after he had identified the social care crisis as among his top priorities if he were to become prime minister. He was Britain's longest-serving health secretary, in the post between 2012 and last year.'*[24]

The Covid-19 crisis has exposed the way in which social care in the UK – care homes and care at home – is too often treated by government and by the NHS. In May 2020, just as the total rate of coronavirus deaths was falling, new surges in care homes in London were reported.[25]

The policy of clearing hospitals of patients – on March 17 2020 alone, 15,000 patients were transferred out of hospitals into, mostly, the care home sector – spread the virus amongst the most vulnerable in our society.[26]

'Care homes in England and their elderly residents were effectively 'thrown to the wolves' during the coronavirus crisis, according to a scathing parliamentary report, which accused the government of a host of leadership, accountability and transparency failings. Many of the problems were attributed to the lack of central control, with responsibility for adult social care spread between the Department of Health, local government and private and non-profit care providers…. Almost 20,000 care home residents died with confirmed or suspected coronavirus between March 2 and June 12 2020, according to official figures. The cross-party committee of MPs said the crisis revealed the 'tragic impact' of delays by successive governments to reform the social care sector, which has been treated as the NHS's poor relation, and subject to years of underfunding. This was 'compounded by the government's inconsistent and at times negligent approach to giving the sector the support it needed', they added. Although the NHS declared the highest level of emergency for hospitals on January 30, 2020 and started to implement protective measures, it was not until April 15, that year that the government published an 'action plan for adult social care,' the report said. By this time 25,000 patients had been discharged from hospitals to care homes without knowing whether they had the virus since the start of the pandemic. The report said the lack of testing was an 'appalling error' even though 'there was clear evidence of asymptomatic transmission of the virus" from the beginning of April. The number of first-time outbreaks in care homes in England peaked at 1,009 in early April and by mid-May about 5,900 homes, or 38 per cent of the total, had reported at least one outbreak, the report found.'[27]

How to fix social care, and how to integrate it with healthcare

Immediate merger

SECTION 4

The care home and homecare sectors should become fully integrated parts of the Integrated Care Systems, operating under the NHS brand and managed as indivisible line-reports if they are in receipt?????? of public money.

This would mean merging the existing adult social care departments (represented nationally by the Association of Directors of Adult Social Services (ADASS)) which commission local authority-funded care with coterminous healthcare (and voluntary organisations) under a single decision-making authority.

This would not involve a laying-off of the local authority employed workforce and their replacement by a newly recruited NHS workforce. Rather, as we will describe shortly, this is truly a 'merger of equals' and responsible ICS managers need to make sure that it truly is.

Social care providers of care homes and domiciliary care – the people who actually deliver care to patients – are nearly all private sector or charitable organisations. Although local authorities pay for care for the patients who qualify – and, as above, those who do not qualify are paid for privately, often receiving care in the same care home or delivered by the same domiciliary care provider – local authorities do very little of the actual hands-on care delivered to patients.

The care home and home care providers should not be nationalised, as some advocate, but they do need to be contracted in ways that make them comply with the newly combined executive authorities, the ICSs – just as existing private sector providers do, such as GPs. Given that they are receiving public sector money, then they need to be well regulated. A description of how the system would work, and what further regulation is required, is contained in Book 6.

The appropriate scope for such an entity coincides with the existing population size of most adult social care territories, that is about 350,000 people. Within such territories there are typically about 2,500 people in the three major vulnerable groups: the frail elderly with co-morbidities, often living with dementia; those with chronic and serious health conditions such as cancer; and those with severe mental health issues. For each of these approximately 2,500 people, there should be a personalised care plan managed by a dedicated care manager (typically a community matron) covering cohorts of 70-90 people over 'full cycles of care'. This does not exist today.

This scheme is described in more detail in Book 7 as it forms the core organising principle for primary care reform, and completes the integration of community-based care (care home and domiciliary) with primary care. The case of Bromley is used as an example of how it could and should work.

This reform should not be a confusing, counter-productive top-down reorganisation from NHS England and NHS Improvement, but rather a bottom-up process managed by empowered clinicians and managers (both local authority and NHS) on the ground.

Two important footnotes are required. The first is that there will be a one-off cost as social care staff are paid more (and have better pensions) at similar job grades than social care staff. Administratively, it's not difficult as the method was widely used when the transfer of public health responsibility to local authorities was mandated in the Health and Social Care Act of 2012.[28] This was a missed opportunity to stop the 'deckchair shifting' and move to an integrated system. The cost of equalising health and social care pay rates is quantified in the Health Foundation review discussed below.

The second is that child social care would remain a local authority responsibility in a newly designated local authority sector that sits alongside the new coterminous health and adult social care areas. The work between health and adult social care is overlapping – involving, for instance, a frail elderly patient in a care home, or a learning disability patient in a mental health unit – entering hospital, either as an in-patient or outpatient, regularly for specialist services, and receiving continuous GP support from primary care.

Child services, however, do not mostly involve clinical paediatric care, but rather, as described earlier, involves child safeguarding issues, involving a lot of legal work on taking children into care, and managing adoption and foster services. In the devolved system both sets of services – coterminous health and care adult services and 'remaining' local authority services – would sit in a devolved organisation covering 1-5 million people (that is, about 20 such bodies across England) with elected mayors giving them democratic legitimacy.

This arrangement is described more fully in the next Book (Book 3) which describes the broader reform of local government in battling health and wealth inequalities.

Towards a new integrated, patient-centred service

SUMMARY:

The merger is not a takeover of the NHS by local authorities, nor vice versa, but a new integrated, patient-centred service: managing the cultural challenges of a 'merger of equals' is a key task.

SECTION 5

As with any merger, the cultural differences between health and social care must be carefully managed. At one extreme, social workers think that medics jump to a pathological diagnosis too quickly and ignore the social and psychological context of patients. At the other extreme, medics think that social workers are unscientific and lack rigour. Neither view is helpful, and good management is required to blend multiple perspectives into patient-specific therapies.

There is a persistent and often debilitating fatalism in the public sector. Talk of integrating health and social care is received with sharp intakes of breath and head-shaking as the idea of reforming the NHS and local government is dismissed as either too difficult or even disrespectful of hallowed NHS and local authority traditions.

The initial reaction is that it must be a zero- or even a negative-sum game involving either the takeover of local authority responsibility for social care and public health by the NHS or the takeover of regional NHS services by local authorities. If the former – a takeover of local authority responsibility for adult social care by the NHS, or, indeed, a 'merger of equals'. Then it is argued that:

- ***This would denude the local authority of much of its activity and purpose,*** *taking away about 20 per cent of local authority budgets.*[29] *See table below.*[30] *And, with public health, a further 3.5 per cent. Yes, that's right, and the money would be better spent as part of a more efficient, integrated service to patients and citizens. Even so, as we will argue shortly, taking adult social care out of local authorities and putting it into a newly merged ICS would create a tipping point for already beleaguered local authorities, and require that broader local government reform is launched making it more financially secure, and more connected with its local citizens.*

- ***The allocation of money to a new health and social care fund would be complicated*** *because local authorities raise some of their money locally (just over half.*[31]*), whereas the NHS budget is fixed by the Treasury centrally. This is not insuperable as, for the taxpayer, it is irrelevant who takes our money; more important is how well it is spent, and an integrated health and social care service will both save money and improve service.*

There is a 'bigger and better' solution which is to raise taxes for both health and social care in the form of an hypothecated tax, which will be discussed more fully in Book 4.

- ***It would be anti-democratic as local authorities are run by elected representatives whereas the NHS is not.*** *This is a fair objection, and it's why we recommend that the NHS is devolved to the local level and is incorporated into a new system of local authorities that increase democracy by giving elected mayors greater power and authority, as will be discussed Book 3. This devolution needs to be supported both by significantly improved managerial competence whereby well-trained managers are given the authority, and held to account, for delivering high quality, nationally mandated levels of service, and by a substantial and sustained 'fix' to local authority funding which is getting worse by the day. Again, these issues are discussed in more detail in the following book in the series.*

The takeover of the local NHS by local authorities generates other, often equally, strongly held objections. To reiterate, this is not what we are proposing. Instead, this needs to be a 'merger of equals'. Even so, many clinicians would object that:

- ***It overturns Nye Bevan's 1948 victory in taking healthcare responsibility away from local authorities, and creating a national system.*** *The answer is that if there are good reasons to boost local democracy and offer a better, more joined up service for citizens, then Nye Bevan would be for it.*

- ***It will create a postcode lottery.*** *As described in Book 1, we currently have a postcode lottery in both health and social care, hence the UK having the worst health and social inequalities in Europe that is caused not by devolution but rather by the current overcentralisation of power and authority in Westminster and Whitehall.*

- ***Health professionals will refuse to be managed by what they see as low-calibre local authority politicians and managers.*** *There is truth in this. Some councils are efficient and well run, but the managerial demands of sticking to a fixed and known budget in order to pay private sector subcontractors – in the case of adult social care and much of children's social care, perhaps the most complicated local operations – is not difficult.*

On a spectrum of managerial complexity, and therefore the skill and training required, the CEO of a local government is at one end, and the CEO who manages a profit and loss account in a highly competitive, private sector global business is at the other. So, we are not recommending a local authority takeover of the NHS, but rather we recommend that the NHS is devolved to the local level and is incorporated into a new system of local authorities in which managerial competence is improved. National platforms to ensure consistency and to manage the spread of best practice will be required to complement devolution. These national platforms are described in some detail throughout this book series.

The third option is to nationalise social care and integrate it with the centralised NHS at the national level. This is not the answer either:

'Social care is in dire need of attention from decision-makers, but nationalising it is not the answer. Instead the NHS should become more locally accountable. At one level, the issue for social care begins and ends with money – many of its weaknesses in relation to the health service can be traced back to this. The NHS gets its money directly from government and hospitals are paid for what they do. Social care is funded by local government. As council budgets have been cut, spending has fallen, and there is no mechanism to respond to demand…the first priority, however politically difficult, is to fund social care properly.

'But beyond this financial reality, there are deeper problems with a rigid national model that have been further exposed during the Covid-19 pandemic. Instead of being a safety net of last resort in a community-based system of care and support, acute hospital provision dominates the healthcare landscape, sucking in a huge amount of funding and capacity. Without reform to shift away from crisis intervention and towards prevention, hospital budgets will eat up an ever-greater proportion of public service spend.

'Setting up a national social care service risks replicating this bias. A single service would tend towards uniform, building-based services, easily managed and monitored from a Whitehall department, rather than adaptable, community support that would vary between areas. We could learn a lot from other countries. In Denmark, for example, the regions run hospitals but well-resourced municipalities pay a penalty for admissions, embedding prevention and community-based care in the system. There is no question that the care system is in urgent need of funding reform, but nationalising social care wouldn't solve its problems.

'Rather than rush to an institutional response, let's start with people – and ask deeper questions about what would make us all live longer, happier, healthier lives. We could then reimagine a system of health and support to enable that ambition.'[32]

So, the answer is to merge the two systems locally, as described above, and move more towards prevention, as discussed in Book 3.

Mergers and acquisitions (M&A) are not easy to manage in any circumstances, and the merger of health and social care is at the further end of difficulty. The process has to be well managed, drawing on the lessons of major private sector mergers. Ian, my brother was the commercial director and head of M&A at Ocean Transport and Trading when it merged with NFC (Exel) in May 2000.

The merger was, at the time, one of the largest in UK industrial history and created the largest 'pure play' logistics companies in the world. It was, and is, a great success but it was very carefully and thoughtfully conducted, with deliberate respect for the two very different cultures: one priding itself on tight operating standards in warehouse and truck fleet management; and the other inspired by its seat-of-the-pants, can-do mentality in moving freight globally – and Ocean (MSAS) was proud of its fleet-of-foot ability to be the first company to move freight into the USA after the week-long closing of US borders after 9/11.

One crucial technique in integrating the two companies was to avoid internal squabbling by getting the customers – companies like Ford and WalMart – to join workshops to show how the two cultures were both required in order to manage the increasingly global, just-in-time supply chains that were vital for **their** competitiveness.

One clear lesson to be applied to the merger of health and social care, is to keep the patient at the centre of the process – as in the high-risk-care management programme to be described in Book 7 on reforming primary care.

The need for government and the NHS is to 'up its game' when it comes to organisational change in general and mergers in particular. The decision in 2018 to merge King's College Hospital with Guy's and St Thomas' is a case in point. The announcement was made out of the blue, causing much anxiety in the two hospital groups.

And it quickly became apparent that senior management in both NHSE/I and in the individual hospitals (and their boards) had no operational experience or plans beyond making the announcement. The broader context in which the system failed King's College Hospital in 2017/18 is described in the Harvard Business School case study in Book 12.

I myself conducted one of the largest mergers of acute hospitals in the country when the Hammersmith and Charing Cross Hospital NHS Trust was merged with St Mary's Hospital NHS Trust in partnership with Imperial College, London to create the United Kingdom's first Academic Health Science Centre (AHSC). Hospital mergers are at the extreme end of 'merger activity' but the success of this merger, as reflected in patient satisfaction scores up to 12 months after the merger, was based on the concept of a higher principal, that of the AHSC delivering not only service but education and research. Eight such centres now exist and have proven their worth throughout the Covid pandemic, being a key feature of the United Kingdom's ability to innovate in the face of acute health challenge.

Sustainable funding

SUMMARY:

The funding of social care needs a sustainable solution: cash injection in the short term (and an hypothecated tax in the medium term). Recent government announcements do not solve the problem.

SECTION 6

The Johnson Plan to raise national insurance contributions will collect £12 billion a year, nearly all of which will have to go into the NHS to pay for the backlog in surgery – and that is likely to be true not only in the short term but in the longer term as well.

After October 2023, there will be a cap on social care payments (which cover care costs, not accommodation costs in a care home) of £86,000 for people with wealth (including their home) of £20k to £100k this replaces the sliding, means-tested, scale range of £14,250 to £23,250. For those with wealth above £100k, all social care has to be paid privately as opposed to the £23,250 threshold previously.

This extra money will come from younger, employed people, falling the heaviest on those earning less than £50k a year, representing a shift of wealth from them to the already wealthy pensioners (there are no national wealth taxes in the UK and Capital Gains Tax is at a low rate compared to income tax: an average of 15 per cent compared to 25 per cent).

The social care funding gap – caused by the cuts since the Conservatives came to power in 2010 – is about £12 billion a year. The part of the Johnson Plan that introduces the cap on care payments does not actually put any more money into social care. Instead it subsidises private payers so that the about one in ten people who currently pay more than £86k in care fees (before they die) will not do so after 2023. Clearly, this is welcome news for those people, but they are not the people suffering most from the social care system at present.

The people who are suffering most are working age adults with mental health problems (mostly learning difficulties) and poor, elderly people (with wealth less than £23,250). About £25 billion of public money is spent on these two groups of people: just under a half on the 300,000 working age adults and a little over a half on the 550,000 elderly people. Spending on these two groups of people needs to increase because inadequate local authority fee rates mean that services are contracting, and care workers are paid very low wages and are often poorly trained. This situation is unlikely to change as a result of the Johnson Plan.

The Johnson Plan can be seen either as an underwhelming response to the severe health (NHS) and social care difficulties or, more positively, as the first step to more thoroughgoing and much needed reforms of a health and care system that is creaking dangerously at the seams.

These ten reforms will be considered below, after the Johnson Plan is assessed.

Currently, 75 per cent of care home residents die within three years of entering a care home (the average length of stay is just over two years). It takes about 3.5 years to spend the £86k that the Johnson Plan is going to introduce (the current average annual cost of a care home is £36,000, but £12,000 is living cost and is not covered). This scheme will cover a cohort of about 144,000 people per annum, costing the Treasury £2 billion a year at the very most.

An additional cohort of people will benefit from the threshold being raised from £23,250 of savings to £100,000. The financial impact on the Treasury will depend on wealth distribution throughout the country, but generous assumptions – for instance, it is unrealistic to assume that the two cohorts are distinct – could put this figure at an additional £2 billion. This does not account for possible future tightening of health assessments of eligibility or the possibility of money being diverted to the NHS budget.

It is important to note that this extra £4 billion – at most (more conservative estimates put the figure as low as £1 billion a year, is not money that will be put into social care. It is effectively a grant to people who would have had to pay out of their own pockets.

That is, of course, good for the people affected, and will allow many of them to pass on their home to their children (although some would argue that people should sell their home – or at least pay a wealth tax from the windfall, especially in the south east of the country, generated by rising home prices – rather than take the money from the younger generation). Yet it still does not improve the often inadequate care that nearly one million people (see below) receive today, nor allow the 1.4 million people (again see below), who need care but are not currently receiving it due to ever stricter needs assessment criteria, to access that care.

Viewed optimistically, however, the Johnson Plan is a first step in a further 10-point plan to really fix health and social care. These are:

1. *About 300,000 working age adults (mostly with learning difficulties and living in care homes or sheltered accommodation) and 550,000 people (split between care homes and care in their own homes) are too poor to pay for themselves and are paid for by local authorities. This care is basic (due to the low level of fees paid by local authorities) and is provided by poorly paid and undertrained (but hard working) carers.* ***The answer is to spend an extra £15 billion directly on social care.***

2. *A further 1.4 million people have unmet care needs (300,000 with three or more essential everyday tasks, like getting out of bed, going to the toilet or getting dressed[6]) due to the lack of local authority funding – as described in more detail above.* ***A further £5 billion on top of the £15 billion above is required to cater for the people who fail to qualify under the ever stricter assessment criteria since these are not based on need but on what local authorities can afford.***

3. *Spending on both health and social care in the UK is below that of peer European countries.[7] And because they are two separate systems, the higher profile NHS tends to get priority over social care which, over time but less noticeably, increases NHS costs (due to people being more ill when they enter hospital). Much, perhaps all, of the £12 billion a year raised (of which nearly half will go to the non-English nations (Wales, Scotland and Northern Ireland) and schemes such as 'test and trace') will most likely go to shore up the NHS, which has its own cost pressures (especially the surgical backlog).*

   The actual amount needed just for the NHS has been estimated to be nearly twice the amount offered in the Johnson Plan.

   The answer is to pool budgets for both health and social care and give integrated care organisations the responsibility for spending money to optimise outcomes for patients (moving money, for instance, from expensive hospitals to preventive and pre-emptive out of hospital care (high risk care management programmes). The current integrated care systems are a step in the right direction but have no statutory rights over local authority (social care) budgets or policies. They need to be given these rights in a 'merger of equals' as described above.

4. *The two systems are separately funded and managed, and the patient journey (a frail elderly person in a care home, for instance, accessing other community services, the GP, and going in and out of hospital) is disorienting at best and, literally, deadly at worst. Integrated care systems seek better (but still non-statutory) working between local authorities and the NHS. Even so, care is not provided by local authorities, and the private companies that do provide it are often not 'at the table' and, especially for the NHS workforce are often ignored and misunderstood. The distinction between health and social care is an unhelpful and bureaucratic invention. In a truly patient-centred system, the 'whole' person would be assessed, meaning that a penurious 'Mrs Jones' would get both clinical care to treat, say, her cancer, and help to eat daily which her dementia prevents her doing.*

   Many home care and care home operators are well-managed and innovative (in, for example, dementia care, long-term care planning, the use of IT, etc.) and should become more fully integrated into the system. The mechanism for doing this – and for making the patient journey more seamless and a lot safer – is a high-risk-caremanagement programme that puts a plan in place for every vulnerable patient (including both cancer treatment and, for instance, support in eating), managed over full cycles of care by a community matron with GPs ultimately owning the plan.

5. *The money raised for health and social care is not ringfenced, and the government can make decisions to move the funds around, often disadvantaging social care which is consumed by poorer people with less voice and voting power.*

   Moreover, the Johnson Plan to raise National Insurance Contributions (NIC) hits hardest both employment – some estimate it may cost 50,000 jobs – and poorer working people.

   The answer is not NIC but instead a designated and hypothecated tax, social insurance effectively raised solely for health and social care, with a clear five to ten year budget (allowing optimised spending decisions) and structured so that it is more progressive (richer people pay a higher percentage of their income), it includes a wealth tax, and it includes 'sin taxes' (on bad food, for example, and bad behaviours such as missed NHS appointments).

6. *Free NHS healthcare excludes conditions that are clearly medical conditions – especially dementia and frailty which means that a poor, frail, elderly person living in Birkenhead, for instance, pays her own money towards care (until she meets the £86k threshold if she owns assets above £20k) whereas a resident Russian oligarch living in London gets free cancer care perhaps worth thousands of pounds.*

   Dementia should be reclassified as an NHS-treatable disease and, over time (ten years perhaps) more NHS charges should be levied on the most wealthy in our society.

7. *The care workforce is underpaid and underskilled (although very hard working). An NHS nurse's average pay is £33,000 a year (the same nurse is paid about 10 per cent less if they work in a care home.)[33] Care workers get paid £8 an hour on average (£14,000 a year) and many prefer to work in the better-paid NHS as healthcare assistants (on £20,000 a year) doing the same job, or even as a much-less-stressed Tesco cashier on £16,000 a year.*

   The answer is to raise pay for care workers, and to integrate their qualifications and careers into a combined health (NHS) and social care structure. Re-introducing a State Enrolled Nurse (SEN)-type qualification would be a good start at a level between nursing associate and State Registered Nurse (SRN). Clearly, skill levels, qualifications and experience need to be well-defined and closely regulated.

8. *Cash-strapped local authorities (especially in Labour-controlled and poorer northern constituencies) who have had revenues cut by 20 per cent since 2010 (largely as a result of a 40 per cent real terms cut in funding from central government) are unable to pay adequate fee rates. As a result, wage rates are low and in-home care businesses have gone out of business. At the same time local authority-funded care/nursing home beds have contracted by 15 per cent since 2010 (at a time of growing need, and an increase in private beds)[34]. The situation has been worsened by damaging financial and operational leverage strategies by private equity and hedge fund companies.*

The answer is to regulate the industry so that:

(a) local authorities (or, better, integrated care organisations) pay fee rates that allow the payment of reasonable wages, and support capital investment in new stock, and

(b) profits are regulated to give a low, utility rate of return that prevents 'sharp' financial practice (for privately paid-for beds as well as publicly paid-for beds) by private equity companies and hedge funds.

9. *Family carers get £67.60 a week if they give at least 35 hours care to someone classified as needing care, and, if they give this care alone. There are 1.2 million carers living in poverty.*

   The answer is to raise the carer allowance (and also apply fewer restrictions – for instance you do not qualify if you earn more than £128 net a week in other employment) and give greater support to unpaid carers.

10. *Research over the last ten years (especially the Marmot Reports, 2010 and 2020) has shown that health and social care can affect (for better or for worse) as much as up to 20 per cent of a person's health whilst the rest is determined by genetics, life chances and lifestyles. Infant mortality for the poorest in the UK has risen since 2011. And a boy born today in the most deprived areas of England can still expect to live about 19 fewer years in good health and die nine years earlier than a boy born into the least deprived area.*

    The answer is a fundamental change of policy to give the most disadvantaged in our society a better start in life. This will require devolution of power from Whitehall and Westminster so that democratically elected local representatives can better shape the local environment (public health, employment, education and housing, as well as health and social care) to better serve the needs of the local population.

The Health Foundation has analysed how much it would take to fill the funding gap.[35] They have looked at three criteria that would drive funding decisions:

- *Stabilising the current system including paying care workers more and equalising them with equivalent workers in the NHS,*
- *Improving access to care so that the people who fall through the cracks are now covered, and,*
- *Providing social protection against care costs by introducing a cap on what an individual needs to pay, based on Dilnot's proposals.*

They have produced seven scenarios quantifying these various combinations and the degree of cover provided. They have then consolidated this analysis into a recommendation to government that neatly summarises both the extent of the crisis, the importance of recognising and rewarding the skill and dedication of the social care workforce, and the necessary cost of fixing it. It is worth quoting in some detail.

'The case for making a sustained investment in social care has never been stronger – the toll the pandemic has taken on this sector means that social care is no longer a hidden problem, but one that the country as a whole understands. We urge the government to now address this crisis as a matter of urgency.

'…The funding increase we are calling for is significant at a time when public finances are likely to be stretched, but the pandemic has made it clear that doing nothing is no longer an option. Providing adequate funding for social care will also help the NHS, and may itself have positive economic and long-term social impacts, given that social care is an important part of the economy.

'We believe the starting point must be an increase in annual funding of £3.9 billion by 2023–24 to meet demographic changes and planned increases in the National Living Wage. However, such an increase alone will not address shortfalls in the quality of care currently provided, reverse the decline in access or stop the market retreating to providing only for self-payers. Further funding to address these issues is therefore also required as a matter of urgency.

'….Improving the level of recognition afforded to social care workers must be a key focus for the government to safeguard the future of the social care workforce. Not to do so would be to fail the many thousands of care workers who have worked so tirelessly during the coronavirus pandemic.

'….It is essential that the government provides a sustainable basis for continued rises in pay above and beyond increases to the National Minimum Wage and in line with increases given to NHS staff. Evidence from the Health Foundation and others demonstrates that this must be supported by investment: the Health Foundation estimates that to increase the average pay in social care to just 5 per cent above the National Living Wage, while meeting future demand, would cost an extra £3.9bn per year by 2023–24.

'….The Secretary of State has committed to increasing the alignment between the training of NHS and social care staff and his stated ambition being to make it easier for a registered nurse, for example, to move between the NHS and social care is an important one….It is important that this increase in alignment of training is not focused solely on nurses and other social care workers with a registered qualification, or allowing care staff to more easily move to higher paying roles in the NHS. Establishing a clear career path with substantial training opportunities, more effectively aligned with the NHS is vital for all entrants to the social care workforce….

'….We are concerned that lower qualified social care workers and those without qualifications at all are not eligible for the new NHS visa, not least because it undermines parity of esteem between the health and social care sectors. The government should accept the Migration Advisory Council's (MAC's) recent recommendation to add senior social care workers to the shortage occupation list…

'….The current system is unfair, confusing, demeaning, and frightening for the most vulnerable people in our society, and their families. It is therefore essential that the government tackle the problems in the care sector as a priority. The success of the reforms in Japan has demonstrated that it is possible for a government to grasp the nettle and take decisions on social care which, though they may be initially difficult, lead to positive and lasting change which is widely accepted by society.

'The Lords Economic Affairs Committee's report makes a persuasive case for the introduction of free personal care. This would cost around £5bn per year, which is only a small fraction of what is currently spent on NHS care. It would also simplify the current confusing arrangements for people who need care, and would put social care on a more equal footing with the NHS by ensuring that all basic care needs are met free at the point of need. Free personal care was also recommended by a joint report of the Health and Social Care Committee and Housing, Communities and Local Government Committee in 2018.

'We also strongly endorse a lifetime cap on care costs which could be implemented swiftly under the provisions of the Care Act 2014. Such a change would focus resources on the most severely affected people, protecting those with very high care needs and remove the injustice which sees the NHS cover certain types of extreme care costs but the social care system not cover others, including those with dementia, motor neurone disease or many other neurological conditions.

'Any reform package must therefore introduce a cap on care costs to protect people against catastrophic costs. We believe this should be set at the level specified in Sir Andrew Dilnot's original report, namely £46,000 which will cost around £3.1bn by 2023–24….

'….We believe that the starting point for the social care funding increase must be an additional £7bn per year by 2023–24 to cover demographic changes, uplift staff pay in line with the National Minimum Wage and to protect people who face catastrophic social care costs. This represents a 34 per cent increase from the 2023–24 £20.4bn adult social care baseline projected budget at today's prices….

'But we are clear that this is only a starting point. It will not provide any improvement in access to care, which is urgently needed and would be improved through introducing free personal care as recommended by previous select committee reports from both the Lords and the Commons, which we continue to endorse as worthy of consideration. The full cost of adequately funding social care is therefore likely to be substantially higher than £7bn, potentially running to tens of billions of pounds. We recognise these are substantial increases at a time of severe financial pressure but the evidence we have heard both from those who use social care, and frontline social care workers suggests that the gravity of the crisis now facing the social care sector requires a bold response if we are to recognise the sacrifices made recently by the social care workforce and—most importantly—look after vulnerable people in our society with the dignity and respect they deserve.'[36]

This short term injection of £10 billion or so – adjusting the Health Foundation figure to account for increased need and improved access – is not going to fix the problem in the medium term. The issue of social care will quickly slip from decision-makers minds once the immediate short-term crisis is alleviated. In order to enshrine the better levels of care for the vulnerable, two further changes are required: the first is to devolve power to fully accountable local Integrated Care Systems as described in Book 3.

The second is to merge the two systems of funding for health and social care into a single hypothecated tax, which is considered in more detail in Book 4.

The wider opportunity

SUMMARY:

Merging adult social care and the NHS locally will trigger an opportunity for a more thoroughgoing reform and modernisation of local government.

SECTION 7

Alongside central government funding cuts of nearly 50 per cent since 2010-11, local authorities are facing strong demand and cost pressures, and no reduction in their statutory obligations to provide services. Local spending is becoming more narrowly focused on social care due to the statutory need to meet the growing demand and falling central government funding, alongside some council tax increases that are restricted to use only for adult social care.

The increasing demand for social care spending, although still not at the levels required to care adequately for the most vulnerable, is moving local authorities to the position that social care is a larger and larger part of their activity.

This presents two arguments for separating social care from other local authority services, and merging it with health: first, as social care becomes more demanding, so the artificial separation from health places greater cost on the NHS; costs not only in terms of inefficient spending of tax pounds such as when local authorities keep patients in hospital for as long as possible, to save them money (about £850 a week even though an equivalent weekly cost for a hospital bed is over £3,000), but also through the debilitating effect of longer-than-necessary hospital stays.

Secondly, local authorities need to focus more on the other drivers of life chances – employment, education, housing, and the criminal justice system that, as we will argue in a following book in the series – are the major drivers of a person's health and wellbeing.

The answer is devolution to democratically elected mayors who have competent executives to manage two major sets of services: merged health and social care on the one hand; and the other community services, such as education and planning, together with beefed up powers over employment and housing.

Reductions in central funding are occurring at the same time as there is increased uncertainty about income from other local revenue sources, such as business rates, the new homes bonus grant, and fees and charges. This problem will be turbocharged by the economic impact of the Covid-19 crisis which will severely damage the high street as people switch to online spending.

The upshot is that it is increasingly hard for local authorities to find further savings and balance their books, resulting in a decline in nonsocial-care services, such as rubbish collection and libraries. Moreover, conditions attached to central government funding risk creating a centralised local authority financial system where the scope for local discretion is being eroded. Consequently, there is the real prospect that we will see other local authorities join Northamptonshire County Council in issuing a Section 114 notice, which gives warning that it may not meet its legal obligation to ensure its revenues cover its spending.

Following the 2019 Spending Review, certainty about local authority funding disappears from 2020-21 (even before covid). The financial year 2019-20 was the last of the current four-year funding settlement, which provided some funding certainty and stability to support the medium term planning of councils that accepted it – which was the vast majority of them.

But even during this four-year settlement, there have been numerous changes outside the settlement that have added to the uncertainty, further undermining strategic planning and creating significant risks for value for money. These changes have included the revised referendum limits, the re-purposing of some New Homes Bonus funding to support adult social care, the introduction of (and subsequent changes to) the adult social care precept, and multiple new adult social care funding announcements.

The uncertain future is compounded by not knowing whether local authorities' retention of 75 per cent of business rates will be the government's preferred long-term funding mechanism for the sector, nor the outcome of the Fair Funding Review, which will determine the distribution of money from the Spending Review across authorities. With some councils now spending almost 60 per cent of their total revenue budgets on social care, perhaps of most interest to the sector is the long-awaited Social Care Green Paper (originally promised in March 2017).[37]

Furthermore, the Social Care Green Paper only directly addresses adult social care issues, despite children's social care being the area of local government spend under most financial strain. Local government is hardly the only sector struggling with the uncertainties around leaving the EU. But to date there has been an underestimation of the sector's role and responsibilities in managing the impacts of the UK's exit from the EU. Civil contingencies can only ever be dealt with at a local level.

EU structural funds, including national match funding, were worth £2.4 billion a year to the UK. So the UK's exit from the EU also brings uncertainty about the size, distribution, and expectations of the UK Shared Prosperity Fund, which is planned to replace these EU funds.

One way local authorities are responding to austerity and uncertainty is by increasing their commercial activities. The Secretary of State in the coalition government called for local authorities to become more entrepreneurial, and many have done just this. Commercialisation isn't simply investing in shopping centres – there are many other ways in which an authority can adopt a commercial mindset. But it's the borrowing from the Public Works Loan Board and using this to invest in retail and other uses, such as office space, that has drawn the attention of HM Treasury, the Ministry for Housing, Communities and Local Government (MHCLG), and the Chartered Institute of Public Finance and Accountancy (CIPFA).

Such investment carries risks and local authority governance has weakened in recent years. So it is not surprising that in December 2018 the MHCLG minister, seeing some authorities borrowing upwards of 30 times their annual revenue budgets, suggested that the levels of borrowing in some authorities are too high, and it would be 'prudent and quite frankly odd' if government didn't look closely at them.[38]

This time bomb is going to explode soon, hastened by the economic effects of the pandemic. These investments in retail and commercial real estate might well turn sour, especially given the probable effect of Covid-19 reducing the demand both for retail and office floorspace. Now that social care has become such a large part of a local authorities' spending, so the funding impact will fall most harshly on vulnerable British adults and children.

These pressures have to be addressed, and the core pressure, the rising social care crisis, means that the right place to start reform is to grasp the nettle of health and social care integration as the trigger to more thoroughgoing reform of local government – from its funding right the way through to devolution that allows place-based action to improve not only the health and wellbeing of the local population, but also their fundamental life chances. The time to act is **now**.

Table 1: Estimated net current expenditure by service, England, 2019-20 and 2020-21, in 2020-21 prices

£ million

	Real term: adjusted to 2020-21 prices by GDP deflator			
	Net Current Expenditure 2019-20	Net Current Expenditure 2020-21	Real terms change (£m) Change	Real terms change (%) *Change*
Education services [f]	34,972	34,424	-548	-1.6%
Highways and transport services (excl. GLA)	2,909	2,815	-93	-3.2%
Highways and transport services (GLA only) [h]	2,051	1,097	-954	-46.5%
Children's Social Care services	9,284	9,812	528	5.7%
Adult Social Care services	17,118	17,693	575	3.4%
Public Health services	3,305	3,316	10	0.3%
Housing services (excluding Housing Revenue Account)	1,713	1,808	95	5.6%
Cultural, environmental and planning services	8,719	8,986	267	3.1%
of which:				
Cultural services	2,170	2,193	24	1.1%
Environmental services	5,274	5,413	138	2.6%
Planning and development services [e]	1,275	1,380	105	8.2%
Police services	12,369	12,985	616	5.0%
Fire and rescue services	2,231	2,284	52	2.3%
Central services [g]	3,027	3,067	40	1.3%
Other Services [e]	346	530	183	52.9%
Total Service Expenditure [g]	**98,046**	**98,818**	772	0.8%

Table 3: Budgeted revenue expenditure and financing, England, 2019-20 and 2020-21, in 2020-21 prices

£ million	adjusted to 2020-21 prices by GDP deflator			
	Net current expenditure 2019-20	Net current expenditure 2020-21	Real terms Change (£m)	Real terms Change (%)
Government Grants: [a]				
Revenue Support Grant [b]	666	1,582	916	137.6
Police grant	7,628	7,944	315	4.1
Education grants [c]	30,673	29,295	-1,378	-4.5
Public Health Grant	2,991	3,016	25	0.8
Social Care Support Grant	390	1,331	941	241.2
Improved Better Care Fund	1,724	1,992	268	15.5
New Homes Bonus	912	890	-22	-2.4
The Private Finance Initiative (PFI)	1,244	1,177	-67	-5.4
Other grants inside AEF	*3,696*	*4,648*	952	25.7
Specific grants inside AEF	41,631	42,349	719	1.7
Total Government Grants:	**49,925**	**51,876**	1,950	3.9
Finances:				
Revenue expenditure	**101,145**	**102,416**	1,271	1.3
Retained income from Business Rate Retention Scheme [b]	**17,422**	**16,549**	-872	-5.0
Appropriations to (-) / from (+) revenue reserves	**1,229**	**441**	-787	-64.1
Other items [f]	**472**	**434**	-39	-8.2
Council tax requirement [g]	**32,098**	**33,116**	1,018	3.2

SUMMARY

The logic explored in this book has been:

- *The integration of health and social care is long overdue and should happen forthwith.*

- *Real operational integration, and efficiency savings, will require that funds are pooled and allocated based on the best return to improving health outcomes. This in turn leads to the logic for an hypothecated tax. In the case of local authority funding, this will likely require legislative change as there is a legal duty for councils, section 114, to balance their budgets (unlike the NHS which regularly overshoots its budget, but gets bailed out).*

- *But adult social care is about 20 per cent of local government spending – and as much as 60 per cent in some local authority organisations [iii] - and integrating it with NHS services into a new Health and Care System (an expanded ICS) makes the remaining services (children's services [iv], community/universal services, schools, roads, etc.) increasingly marginal.*

- *This is exacerbated by a dwindling funding base for local authorities as business rates decline (due to online shopping), central government grants, which account for about a half of local authority funding, decline (as, in particular, the NHS is prioritised more highly); and council tax rises are politically difficult.*

This logic will be extended in the following book along the lines of:

- *The time has come to take a more radical view of a system of local authority activity that is increasingly stressed. Moreover, the system is complex and confusing, with upper tier councils (mostly county councils), lower tier councils (district councils), unitary authorities, London boroughs, metropolitan boroughs, and, where there are mayors, combined authorities.*[39]

iii In Sefton Council, an upper tier council, spending splits £90 million for adult (61%), £28 million for children's services and £30 million for universal services (such as family centres). There is a further spend of £20 million, to make a total of £163 million. Sefton Council employs 3,500 people.

iv Most adult services delivered by local authorities (usually upper tier councils and unitary authorities (https://lgiu.org/local-governmentfacts- and-figures-england/) involve caring for people with physical health issues (mostly frailty/dementia, and mental health) whereas children's services rarely involve health issues, which are delivered by NHS paediatric services. Spending on children's services in local authorities in 2019 was £8.8 billion (https://local.gov.uk/sites/default/files/documents/LGA%20briefing%20-%20General%20debate%20on%20spending%20on%20children%27s%20services%20WEB.pdf). About half of this is spent on children already in the care system (over 70,000). A further 25% is spent on safeguarding and protection schemes, with the remainder spent on a range of services including youth services, 'sure start', etc.

- *And this is especially true as research, especially the Marmot Report of 2010[40] (updated in 2020, and considered further in a following book) has highlighted the growing problem of health inequalities, driven in large part by a centralised system that does not allow local authorities to deploy the full range of activities (especially education, employment and housing) to give poor people better life – and therefore, health – chances;*

- *Underpinning this greater emphasis on devolution and 'place based', customised solutions to local problems, is the growing recognition that too many communities in the UK have lost cohesion which, in turn, further fuels inequality;*

- *Decentralisation and devolution, then, make sense in every domain – health, social and economic – but without devolution of political power through regionally elected mayors, they lack legitimacy.*

This is clearly a bold and radical agenda. Is it worth it? Yes, given the failure of centralisation and the alarming rise in inequalities, laid particularly bare in the Covid-19 crisis. Government does not have a good track record of managing complex change programmes. The answer is to become better at change management rather than to put integration and devolution into the 'too difficult' box, where it has lain for so many decades. The principles of effective change management are described in Book 12. Perhaps the most important principle is that the programme needs to be piloted in the most progressive areas so that lessons can be learnt, and these can be used to roll out devolution across the country in a staged and deliberate fashion. It will take time – probably five years or more – but the programme will have a major impact on improving people's lives.

The practical challenges, and opportunities, of merging the two systems are described in Book 6.

The next book (Book 3) examines local government reform, a necessary condition if the health and wellbeing of the UK population is to be improved sustainably.

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His pioneering role in establishing the AHSC was recognised in the NHS Leadership Awards, where he was named Innovator of the Year in 2009. The *Health Service Journal* listed Professor Smith in its 2009 rankings of the top 30 most powerful people in NHS management policy and practice in England, where he was the only NHS chief executive to be included.
His contribution to this book-series is solely in a personal capacity.

RADIX

VOLUME TWO

PROFESSOR STEPHEN K SMITH

THE BEST NHS?