The Health Devolution Commission's Submission to

the Health and Social Care Select Committee Inquiry

Adult Social Care Reform: The Cost of Inaction

THE HEALTH DEVOLUTION COMMISSION

The Health Devolution Commission is an independent, cross party and cross-sector body working to champion and support the successful implementation of devolved and integrated health and social care services across England. When it was established in 2020 the commission's Co-chairs were the Rt Hon Andy Burnham and the Rt Hon Norman Lamb. Its current Co-chairs are Dr Nik Johnson, Mayor of Cambridgeshire and Peterborough and lead M!2 Mayor on Health Issues, and Imelda Redmond, CBE, former National Director of HealthWatch.

EXECUTIVE SUMMARY

The Commission believes that it is not possible to create a financially sustainable and successful National Health Service without a strong and stable social care system. The two systems rely upon each other to:

- deliver seamless, personalised care and the best health outcomes
- be efficient and productive in their respective use of public resources
- recruit and retain a well-trained and flexible workforce across both systems, and
- respond effectively to growing demographic demand for their services

The government must fix social care if it is to fix the NHS. This is particularly the case for people who are dual users of both services. Approximately one in six of all adults in England may receive both NHS healthcare and social care services, with this figure being much higher for older adults.

The impact of previous inaction on the reform of social care has fallen upon service users, patients, unpaid carers, social care providers local government, hospitals, primary care, community health services and social care providers. This has also had a direct impact on a missed opportunity to grow the economy, particular in low-income areas of the country.

Whilst the debate on fixing the social care system has often focused on inaction to tackle the catastrophic costs for those people who pay for their care (self-funders), it is the impact of inaction on improving the quality, quantity, funding and flexibility of the delivery of social care that is the most urgent and immediate priority for action.

- **Impact upon on those who draw upon social care** - too many people with low levels of care needs are unable to access publicly funded care

- **Impact upon those who provide social care -** low pay throughout social care sector persists leading to high vacancy levels and understaffed services, high turnover of care staff, high staff recruitment and training costs, increased recruitment and training of overseas workers, and high use of expensive agency staff to fill vacancies to ensure safe running
- **Impact on unpaid carers -** greater pressure on unpaid carers – families and friends who have to fill the gaps in care services
- **Impact on the NHS -** inevitably increased the numbers of people who use primary care and community health services, the numbers who are admitted to hospital, and the numbers who are unable to be safely discharged from hospital to home. All of these impacts have led to increases in unnecessary and avoidable costs within the NHS.
- **Impact on the economy -** a missed opportunity to have a major economic impact on the lives of millions of people, on communities in very part of the country, and on the economy as whole

The current instability and financial unsustainability of the social care system is also a major barrier to developing truly integrated care systems.

This submission does not go into detail regarding the impact of inaction on reform that would benefit self funders – the Dilnot 'cap' - but the Commission would urge the Committee to press the government to take early action to establish a cross-sector, cross party Commission to undertake a rapid review to address this core question and make recommendations for change in the lifetime of this Parliament.

The government should also use the Spending Review 2025 (2026-2029) to spell out and begin to implement its plans for the future development of the social care system. ***These plans can and should be separate from any process to develop a cross-party consensus on the Dilnot "cap" and how that specific reform will be funded.***

The five main areas for action now are investment and reform to:

- solve the immediate funding crisis (created by unfunded increase in ENICs and NMW)
- deliver an interim uplift in care workers' pay and develop a social care workforce strategy
- improve social care capital
- support better care commissioning to stabilise the social care system, and
- invest in the care system infrastructure

In conclusion, the Spending Review 2025 (2026-2029) provides a unique opportunity to address previous inaction on social care reform and tackle a wide range of social care concerns by creating a fully funded social care strategy that, over time and with clear milestones, will build a strong, stable and high-quality social care system that is effective in its own right to meet people's care needs; contributes as a partner to delivering a strong, stable and high-quality NHS; and acts as a key engine for growth in the economy.

Prepared by Phil Hope and Steve Barwick of the Health Devolution Commission Secretariat and agreed by the Co-chairs of the Health Devolution Commission, December 2024

CONTENTS **PAGE**

INTRODUCTION

The Commission welcomes the decision of the recently established DHSC Select Committee in Parliament to conduct as its first inquiry an investigation into the cost of inaction on adult social care reform.

This submission begins with a summary of the value of social care system in its own right, describes how the health and the social care systems are highly interdependent for their success and financial sustainability, identifies the patient groups who are the dual users of both NHS health and social care services, summarises the impact of inaction on social care reform and identifies 5 key areas for reform.

This submission does not go into detail regarding the impact of inaction on reform of how the social care system is funded but the Commission would urge the Committee to press the government to take early action to establish a cross-sector, cross party Commission to undertake a rapid review to address this core question and make recommendations for change in the lifetime of this Parliament.

The Commission believes that the government's Spending Review 2025 (2026-2029) provides a unique opportunity to address the consequences of previous inaction on social care reform to deliver a funding settlement that will support a growing, financially sustainable, high quality, publicly funded social care system; and provide a firm foundation for the development of a National Care Service.

1 THE VALUE OF THE SOCIAL CARE SYSTEM

Purpose and scope

Social Cares Future have summarised what they see as the purpose of social care:

> ***"We all want to live in the place we call home, with the people and things we love, in communities where we look out for each other, doing the things that matter to us."***

Care and support covers the wide range of activities that help people who are older or living with a physical or learning disability, or physical or mental illness, or who may be homeless, or have drug and alcohol dependencies, to live independently and stay well and safe.

Local government have the main responsibility for publicly funded care, with care and wellbeing statutory duties outlined in the Care Act (2014). Beyond this, millions of people are supported in many different ways. It is a very diverse market of independent care providers including residential care, home care services and personal assistants.

Size and shape

Over 1 million adults drew upon care and support in 2023/24 whilst the Adult Social Care Activity and Finance Report shows that local authorities received over 2 million requests for support. More than 850,000 people drew on publicly funded long-term care. In addition, there were over 280,000 episodes of short-term care. In 2018, the National Audit Office estimated that people spent £10.9 billion of their own money on social care.

More than 1.5 million people work in adult social care. According to Skills for Care data, this is over 5% of all jobs in the English economy – more people work in social care than the NHS. However, the Kings Fund found that in 2022/2023 the overall social care vacancy rate was 9.9%, or 152,000 full-time equivalent (FTE) roles. This is nearly three times higher than the overall UK vacancy rate of 3.4%. As the proportion of the population aged 65 and above is anticipated to grow from 10.5 million to 14.5 million between 2020 and 2040, Skills for Care estimate that by 2040 the adult social care sector will require 540,000 extra new posts (equivalent to 29% growth).

The adult social care provider market in England comprises over 18,500 organisations providing care and support across 40,000 establishments, and almost 60% of these are non-residential services. 85% of providers have fewer than 50 employees, and large organisations (250+ employees) made up just 2% of the total number of organisations. There are also 65,000 people employing their own care and support staff directly as personal assistants through local authority personal budgets.

Adult social care adds £68 billion to the economy every year. The total wage bill of the sector in 2023/24, calculated using Skills for Care data, accounted for around £27.9 billion**.** There is a 28% difference between the employment rate of disabled and non-disabled people. Social care is key to unlocking the economic potential of everyone in our communities.

Unpaid carers

Unpaid carers are the backbone of health and social care. According to census data, there are over 5 million carers in England, though Carers UK research suggests there might be as many as 10 million. They contribute £164 billion a year to the economy, the equivalent to a second NHS. Carers UK found that in 2024, 61% of unpaid carers were worried about living costs and managing in the future, and over a third (35%) don't feel confident they will be able to manage financially over the next 12 months. According to the Future Social Care Coalition, on average, 600 people a day leave work to provide care.

Growing demand and cost

Social care operates a financial assessment (a 'means test') to decide who is eligible for publicly funded care. The 'upper threshold' decides the level of savings and other assets people can have and still qualify to receive publicly funded care (£23,250). The lower that figure is, the fewer the people who qualify.

Fewer people are receiving publicly funded long-term care and support despite an increase in requests**.** According to the Kings Fund, if the threshold for eligibility had increased in line with inflation, in 2022/23 it would have been £7,080 higher.

By 2040, the number of people living with major illness could increase by 37%, nine times the rate at which the working age population is expected to grow. The Health Foundation estimates that meeting growing demand for care, enabling more people to access publicly funded care, and improving services could cost an extra £18 billion by 2032. Skills for Care estimates that, based on growth of the population aged 65 and above, by 2040 the sector may need 540,000 extra new posts (29% growth).

In 2023/24, total expenditure on adult social care rose to £27.1 billion**.** Despite growing demand for social care, adjusting for age, social care spending per person in 2024/25 will be an estimated 5% lower in real terms than in 2009/10**.**

According to the Kings Fund, since 2015, the average weekly amount paid by local authorities for older people has increased by over 25%, and the average hourly rate for home care has increased by 17%. Despite this, in March 2021, the National Audit Office reported that most local authorities were only able to afford below sustainable rates for care and support due to financial challenges. In 2024, ADASS found 81% of councils were due to overspend on their adult social care budgets. Failure to close the adult social care resourcing gap has left councils struggling to square their legal duty to set a balanced budget with their duty to provide statutory services.

2 THE INTERDEPENDENCY OF THE SOCIAL CARE SYSTEM AND THE NHS

The Commission believes that it is not possible to create a financially sustainable and successful National Health Service without a strong and stable social care system. The two systems rely upon each other to:

- deliver seamless, personalised care and the best health outcomes
- be efficient and productive in their respective use of public resources;
- recruit and retain a well-trained and flexible workforce across both systems;
- respond effectively to growing demographic demand for their services

The government must fix social care if it is to fix the NHS. This is particularly the case for people who are dual users of both services. Approximately one in six of all adults in England may receive both NHS healthcare and social care services, with this figure being much higher for older adults (see appendix 1 for a complete analysis). The overlap between health and social care is more significant for people with complex or long-term health conditions or those with disabilities across all age groups.

This intersection between health and social care is key especially given the increasing demand for both services due to an aging population, rising chronic conditions, and the need for integrated care pathways to address both medical and social needs. There are three main groups who are dual users of NHS health and social care services and for whom integration between the systems is essential for success:

- older adults (65+) that are the highest proportion of patients who use both NHS healthcare services and social care services, particularly for chronic conditions, dementia, frailty, and rehabilitation.

- working age adults with disabilities, long-term conditions, or complex needs (including mental health) who require both NHS and social care services

- children with complex needs, disabilities, or those involved in safeguarding issues who may need both types of services.

Older adults

Older adults are the most likely group to require both NHS healthcare services and social care services (such as residential or home care) and are most likely to be affected by inaction on social care reform. Many are managing long-term conditions like heart disease, diabetes, dementia, or arthritis, which may require frequent medical care (e.g., from GPs, community services, or hospitals). These individuals may also require social care to help with daily living activities such as bathing, dressing, mobility, or managing medications.

A significant number with dementia or frailty often have complex needs that involve both health care and social care. In 2020, approximately 50% of people with dementia were estimated to also receive social care support (residential or home care).

Older adults frequently experience hospital admissions related to their chronic conditions or acute health issues. After hospital discharge, many of these patients need home care or even transition into residential care for rehabilitation or long-term care.

Estimates suggest that up to one-third of older people who receive NHS healthcare services also receive social care (home or residential care). For those with the most complex needs, like multiple comorbidities, the proportion may be even higher.

Working age adults

The proportion of working-age adults receiving social care is lower compared to older adults, but it can still be significant among those with disabilities, long-term illnesses, or complex needs. This group tends to use NHS services more for acute or episodic care (such as injury, surgery, mental health treatment, or chronic disease management) but may also require social care services in specific circumstances:

Adults with severe mental health conditions, such as schizophrenia or bipolar disorder, often need both medical treatment and social care services. Some may require long-term residential care or community-based services to help with daily activities, especially if they have a disability. Adults with physical disabilities, learning disabilities, or long-term conditions (such as multiple sclerosis) may need ongoing support with personal care, mobility assistance, or other social care services alongside their NHS treatment. Home care services are common for this group.

Following major surgery, accidents, or strokes, some working-age adults require rehabilitation services (e.g., physiotherapy) through the NHS, alongside social care for help with activities of daily living, such as dressing, eating, and mobility.

Children under 18

The demand for both health and social care in children is typically more focused on cases of disability, complex health needs, or safeguarding concerns, rather than general health conditions. Children with complex medical conditions (such as cerebral palsy, autism, or severe developmental delays) may require a combination of health services (e.g., paediatric care, physiotherapy, etc.) and social care services (e.g., home help, residential care, respite care for families).

Children and adolescents with severe mental health conditions (such as eating disorders or psychosis) may need hospital treatment and psychological care, alongside support from social care services to assist with family dynamics, education, or daily care needs.

In cases where children are involved in safeguarding issues (e.g., abuse or neglect), both health services (GPs, hospital treatment) and social care services (children's services, foster care, or residential care) may be involved.

3 THE IMPACT OF INACTION ON SOCIAL CARE REFORM

The impact of previous inaction on the reform of social care has fallen upon service users, patients, unpaid carers, social care providers local government, hospitals, primary care, community health services and social care providers. This has also had a direct impact on a missed opportunity to grow the economy, particular in low-income areas of the country. Whilst the debate on fixing the social care system has often focused on inaction to tackle the catastrophic costs for those people who pay for their care (self-funders) it is the impact of inaction on improving the quality, quantity, funding and flexibility of the delivery of social care that is the most urgent and immediate priority for action.

a) Impact upon on those who draw upon social care

Previous inaction to reform social care and provide sufficient public funding for social care has meant many people with low levels of care needs are unable to access publicly funded care as the limited resources available are allocated to those with higher levels of need. This means that relatively low-cost interventions or support are not provided so, in the absence of services to prevent people's decline in health and wellbeing, more people will eventually and avoidably require higher levels of care leading to greater cost the social care system. The loss of these low-cost, low-level services since the Covid pandemic such as social club activities for adults with learning disabilities or lunch clubs for older people has led to increased loneliness and isolation, and a barrier to accessing other services that support health and wellbeing.

b) Impact upon those who provide social care

Previous inaction to fund fair pay for those who provide frontline care affects their quality of life and the quality of services they provide. And the prevalence of low pay throughout social care has direct impacts on the efficiency and productivity of the whole system. These impacts include high vacancy levels and understaffed services, high turnover of care staff, high staff recruitment and training costs, increased recruitment and training of overseas workers, and high use of expensive agency staff to fill vacancies to ensure safe running. Inaction has had a negative impact on the quality of services and financial sustainability of many social care providers.

c) Impact on unpaid carers

Inaction on social care has also placed greater pressure on unpaid carers – families and friends who have to fill the gaps in care services – that can, in turn, lead to a decline in the health and wellbeing of those carers and put even greater pressure on the NHS. If the health of an unpaid carer declines and is unable to continue to provide care there is a double impact on the health and social care system.

d) Impact on the NHS

Previous inaction to reform social care and support care services that prevent a decline in people's health and wellbeing will have a direct impact on the NHS.

It has inevitably increased the numbers of people who use primary care and community health services, the numbers who are admitted to hospital, and the numbers who are unable to be safely discharged from hospital to home. All of these impacts have led to increases in unnecessary and avoidable costs within the NHS.

There were around 170,000 delayed transfers of care (DTOCs) in England in 2022. The primary causes of delayed hospital discharges in England are the lack of available social care, including home care and residential placements, combined with staffing shortages and budget constraints within the social care sector (see appendix 2 for a full analysis). This issue is exacerbated by delays in assessments, poor coordination between health and social care, and capacity issues both in the NHS and in social care settings.

DTOCs also cause disruption and unnecessary costs to NHS services, as blocked beds reduce the capacity for new admissions and delay care for other patients. The King's Fund estimated that the direct costs of delayed discharges alone (excluding additional costs from activities such as cancelled operations or staff time spent arranging care packages) in 2022/23 was at least £1.7 billion.

The impact on patient health can be significant, including increased risk of hospital-acquired infections (e.g., MRSA, pneumonia; and decline in physical and mental health, particularly in older adults who may experience deconditioning (loss of muscle strength and mobility) during prolonged hospital stays.

e) Impact on the economy

The adult social care sector is a large part of the economy and a major driver of economic growth with over a million service users, a 1.5 million workforce (bigger than the NHS), a £60 billion industry (bigger than the oil industry,) and over 18,000 independent provider organisations. Consequently, previous inaction to reform and improve the social care system has been a missed opportunity to have a major economic impact on the lives of millions of people, on communities in very part of the country, and on the economy as whole.

Inaction has also meant that many working age people have had to leave the labour market to be carers of a family member. In a survey by Carers UK 32% of unpaid carers of working age reported that they had given up work to care which has a direct impact on their family finances but also a direct impact on the economy as they are no longer contributing tax revenue to the government and can claim Carers Allowance to support their caring role.

The government's Supplementary Green Book Guidance 'Wellbeing Guidance for Appraisal', 2021 uses a "WELLBY' – a one-point change in life satisfaction - as an economic measure for the standard value of improving a person's wellbeing for one life. In 2019 this was estimated to be £13,000. Government should be pro-active in recognising the wider impact of improving social care services on the productivity of the NHS and increasing economic growth as it has begun to do in the impact assessment of the 2024 Employment Rights Bill.

4 THE ACTION REQUIRED TO REFORM SOCIAL CARE

The Commission believes action is need to reform social care as 'fixing the NHS' requires also fixing the broken social care system as the two systems are so interdependent. Reform of social care must create the circumstances for achieving greater integration between the two systems at a local level to provide seamless services for those needing health and social care support, help prevent ill-health and reduce the unnecessary costs created by silo working.

The government should use the Spending Review 2025 (2026-2029) to spell out and begin to implement its plans for the future development of the social care system; and these plans can and should be separate from any process to develop a cross-party consensus on a major reform of how the system is funded.

The Commission believes there are five main areas for action - investment and reform - to improve the delivery of social care:

a) Investment to solve the immediate funding crisis

b) Investment in care workers pay and a social care workforce strategy

c) Investment in social care capital

d) Investment in care commissioning to stabilise the social care system

e) Investment in the care system infrastructure

a) **Investment to solve the immediate funding crisis**

The Commission very much welcomes the announcements in the Autumn Budget 2024 of a 6.7% increase in the National Living Wage (NLW) as this will rightly reward hundreds of thousands of frontline care workers where research shown their role is equivalent to much higher paid equivalent band 3 staff in the NHS; and welcomes the additional investment in public services that will give a 3.2% increase in the spending power of local government that funds the publicly funded elements of the social care system.

However, the Commission is deeply concerned at the impact that the Autumn Budget 2024 will have on local government finance and increasing the costs to social care providers of delivering social care services without providing the funding to meet those costs. The Local Government Association estimates that ENICs changes create £1.77 billion in additional costs for councils; £637 million for directly employed staff and £1.13 billion through indirect costs via commissioned providers. It is estimated by the Nuffield Trust that the total cost of the increased employers NI contributions (ENICs) and the increased NLW for social care providers will be some £2.8 billion whilst the amount of ring-fenced support for social care (adults and children) to local government is only £680m (which is included in the calculation of their estimated spending power if local council taxes are raised to the maximum permitted without a local referendum).

This means there is now a serious risk that many private and charitable sector providers of publicly funded social care services (residential and home care) will have to hand back care contracts to local councils and, even more worryingly, consider their future existence, if this imminent funding crisis is not resolved – and quickly.

The impact will not only be on cutting the availability of support for the users of social care, it will also undermine the financial sustainability of local government which will have to pick up the costs of delivering the services, create a 'race to the bottom' in the quality of care provided as contracts are awarded to the cheapest providers. It will also impose additional costs on the NHS which as we have described above relies on social care services to reduce key cost drivers such as delayed transfers of care from hospitals.

The Commission recommends in the strongest possible way that that the Government undertakes an immediate review of the impact of the budget on social care services with a view to finding solutions to the crisis – this could be either awarding additional ring-fenced resources to local councils to enable them to pay higher fees in their care contracts, transferring a small proportion of the large additional resources given to the NHS to social care perhaps through an increase to and reform of the Better Care Fund, or exempting social care providers from the increased ENICs.

b) **Investment in care workers pay and a social care workforce strategy**

At the heart of the challenges facing social care system is staffing – low pay that leads to high vacancy rates, high turnover, poor retention, high training costs and high use of expensive agency staff. The Commission thus welcomes the measures in the Employment Rights Bill to improve the pay and conditions of the care workforce. A Fair Pay Agreement (FPA) for the social care sector is essential and the Commission looks forward to the delivery of that agreement as the core solution to addressing the long-standing problems of low pay, high vacancy rates, and high staff turnover that have dogged the social care sector for too long.

However, as the care sector FPA may not be implemented until 2027/28 because of the legislative and administrative processes that have to be undertaken, the Commission recommends that the government fund a temporary uplift in care workers pay – above the NLW – to help care providers attract and retain staff in a highly competitive labour market, reduce their reliance on costly agency staff and unnecessary training costs, and improve the quality of care that care workers provide.

Skills for Care have published a comprehensive workforce strategy for social care that mirrors the areas of focus in the NHS Long Term Workforce Plan namely: attract and retain; train; transform. The Commission believes this strategy should be adopted by the government as the basis of a government-led strategy with clear milestones for its implementation and funding.

Investment in the paid care workforce that leads to a fully staffed and qualified workforce will directly benefit unpaid carers who will be able to rely on the care system to help them carry out their vital role.

c) **Investment in social care capital**

The Commission believes that additional government investment in care capital is required to fill the gaps in care in some parts of the country – often called 'care deserts'. This is investment that would both improve the availability and quality of care, and lead to economic growth in places where it is needed most. Specific proposals the Commission believes are worth exploring further include:

1. Creating a Social Care Investment Affordable Loan Fund (in the order of £2 billion with very low rates of interest) to support capital investment in care beds and home care services by providers of publicly funded care in low-income locations where the gap between supply and demand for care is greatest. This includes investment in digital ways of working for services such as domiciliary care to increase and improve volume, efficiency and quality of digitally-enabled care.

2. Enhancing the Fund through inviting capital contributions by social investors who receive a balanced mix of financial and social returns

3. Establishing national standards on financial returns and financial transparency for private investors in social care services

d) **Investment in care commissioning and funding mechanisms**

The Commission believes that the skills and capacity of local government to commission social care services have been severely eroded in recent years but that a relatively small investment in the spending review to improve social care commissioning will make a big impact on the quality and availability of social care services. Specific proposals the Commission believes are worth exploring further include:

1. Improve the commissioning capacity within local government to ensure a 'mature' contracting relationship with private and not-for profit care providers

2. Adopt the goal of creating a quality-based market of social care providers to move away from a price/volume 'race to the bottom' in care contracts

3. Provide capacity, training and support for local government care commissioners

4. Develop national standards to regulate the commissioning criteria and processes for awarding and supporting care contracts

e) **Investment in the care system infrastructure**

The Commission believes that to ensure change in social care is 'hardwired-in' there needs to be a significant enhancement in the national infrastructure that supports the social care system. The Commission welcomes the new Adult Social Care Negotiating Body being formed through the Employment Rights Bill as an important new part of that infrastructure.

Specific proposals for strengthening to infrastructure of the social care system that the Commission believes are worth exploring further include:

- Converting Skills for Care into a national statutory Arms-Length Body (ALB) accountable for developing, monitoring and supporting delivery of a new national care workforce strategy

- Ensuring social care has full representation on the Board of Skills England

- Creating a National Care Commissioning body to set national standards, and support and improve the care commissioning capacity within local government

- Investing in and reforming the Care Quality Commission to better monitor and report on the standards of care and support delivered by care providers; and the effective working of the social care system as a whole

- Ensuring social care providers as well as local government commissioners of social care are members of integrated care boards (and not just the integrated care partnerships).

- Ensure social care providers are full members of the Neighbourhood National Health Service structures as they develop.

5 CONCLUSION

The Commission is a long-standing advocate of developing local integrated care systems that embrace the NHS, social care and public health. These services and systems are highly interdependent in both specific aspects of their operation such as delayed transfers of care form hospital to home, and in general as mutually reinforcing each other to provide seamless services and address the wider causes of ill health and ever-increasing demand upon all publicly funded health and social care services.

The current instability and financial unsustainability of the social care system is a major barrier to developing truly integrated local systems. The Spending Review 2025 (2026-2029) provides a unique opportunity to address previous inaction on social care reform and tackle a wide range of social care concerns by creating a fully funded social care strategy that, over time and with clear milestones, will build a strong, stable and high-quality social care system that is effective in its own right to meet people's care needs; contributes as a partner to delivering a strong, stable and high-quality NHS; and acts as a key engine for growth in the economy.

As well as fixing today's challenges, future financial models of paying for social care are needed that take into account fairly the growing proportion of the ageing population who are asset-rich and may require social care.

APPENDIX 1: THE DUAL USERS OF NHS AND SOCIAL CARE SERVICES

Older adults (aged 65+)

Older adults are the most likely group to require both NHS healthcare services and social care services (such as residential or home care).

- *Chronic Health Conditions*: Many older adults in the NHS are managing long-term conditions like heart disease, diabetes, dementia, or arthritis, which may require frequent medical care (e.g., from GPs, community services, or hospitals). These individuals may also require social care to help with daily living activities such as bathing, dressing, mobility, or managing medications.
- *Dementia and Frailty*: A significant number of older adults with dementia or frailty often have complex needs that involve both health care and social care. In 2020, approximately 50% of people with dementia were estimated to also receive social care support (residential or home care).
- *Hospital Admissions*: Older adults frequently experience hospital admissions related to their chronic conditions or acute health issues. After hospital discharge, many of these patients need home care or even transition into residential care for rehabilitation or long-term care.
- *Dual-Needs Patients*: Estimates suggest that up to one-third of older people who receive NHS healthcare services also receive social care (home or residential care). For those with the most complex needs, like multiple comorbidities, the proportion may be even higher.

Working-age adults (aged 18-64)

The proportion of working-age adults receiving social care is lower compared to older adults, but it can still be significant among those with disabilities, long-term illnesses, or complex needs. This group tends to use NHS services more for acute or episodic care (such as injury, surgery, mental health treatment, or chronic disease management) but may also require social care services in specific circumstances:

- *Mental Health Needs*: Adults with severe mental health conditions, such as schizophrenia or bipolar disorder, often need both medical treatment and social care services. Some may require long-term residential care or community-based services to help with daily activities, especially if they have a disability.
- *Disabilities and Complex Conditions*: Adults with physical disabilities, learning disabilities, or long-term conditions (such as multiple sclerosis) may need ongoing support with personal care, mobility assistance, or other social care services alongside their NHS treatment. Home care services are common for this group.
- *Injury and Rehabilitation*: Following major surgery, accidents, or strokes, some working-age adults require rehabilitation services (e.g., physiotherapy) through the NHS, alongside social care for help with activities of daily living, such as dressing, eating, and mobility.

Children (under 18)

The demand for both health and social care in children is typically more focused on cases of disability, complex health needs, or safeguarding concerns, rather than general health conditions. Children's access to both NHS and social care services can occur in certain situations:

- *Chronic Illnesses or Disabilities*: Children with complex medical conditions (such as cerebral palsy, autism, or severe developmental delays) may require a combination of health services (e.g., paediatric care, physiotherapy, etc.) and social care services (e.g., home help, residential care, respite care for families).
- *Mental Health Needs*: Children and adolescents with severe mental health conditions (such as eating disorders or psychosis) may need hospital treatment and psychological care, alongside support from social care services to assist with family dynamics, education, or daily care needs.
- *Safeguarding and Vulnerable Children*: In cases where children are involved in safeguarding issues (e.g., abuse or neglect), both health services (GPs, hospital treatment) and social care services (children's services, foster care, or residential care) may be involved.

The evidence

- According to the 2019 ONS report on Health and Social Care Utilisation, approximately 18% of adults in England reported receiving at least one form of social care (home care, residential care, etc.) while also receiving healthcare services, especially for those aged 65 and over. The data highlights that the demand for both services is higher among older adults due to an increased prevalence of chronic conditions like dementia, diabetes, and arthritis.

- NHS Digital also publishes annual reports on the use of social care services in England. For example, in their 2021 report, they stated that in 2020-21, there were approximately 1.5 million adults in England receiving social care support, and the majority of these individuals had ongoing healthcare needs (e.g., physical disabilities, frailty, or chronic conditions) that required concurrent NHS treatment.

- The Social Care Institute for Excellence (SCIE) points out that the combination of NHS healthcare and social care services is most prevalent among older adults who have multiple comorbidities and frailty; and people with long-term conditions or disabilities who need ongoing medical treatment and assistance with activities of daily living.

- The SCIE's 2021 report on the integration of health and social care highlighted that around 30% of people receiving social care in the community (e.g., home care services) also had contact with NHS services for long-term health management or rehabilitation. This proportion increases for older adults, especially those in residential care settings.

- The NHS Long-Term Plan, published in 2019, projected an increase in the demand for both NHS and social care services due to the aging population and the rise in long-term conditions. According to this plan, approximately 6 million people in England are already living with two or more chronic conditions. Many of these individuals require both NHS health services (e.g., medical treatment, nursing care) and social care services (e.g., help with daily living).

- It is estimated that nearly 50% of older adults who require social care also have significant healthcare needs. For example, people with dementia, one of the leading causes of both healthcare and social care demand, often require continuous support from both systems.

- Research on health and social care integration also provides evidence of the overlap. Studies in this area show that the dual use of NHS healthcare and social care services is particularly evident in populations with complex needs, including older adults with frailty or dementia.; adults with physical disabilities or long-term health conditions like heart disease, stroke, or diabetes; and people with mental health needs who also require personal care support.

- The King's Fund estimates that one-third of older people receiving NHS healthcare also have a need for social care services. Similarly, the Care Quality Commission (CQC) has found that individuals with complex health and social care needs (such as those with dementia or stroke survivors) are more likely to need both NHS and social care services.

- In a 2020 report, the National Audit Office (NAO) estimated that around 1.5 million people in England received publicly funded social care, and the overlap between those receiving health services (particularly hospital care, primary care, and community health services) was substantial. For instance, in 2019-2020, around 70% of social care recipients aged 65+ were also likely to receive some form of NHS care, whether through hospital admissions, outpatient visits, or community healthcare services.

- The percentage of adults who use both healthcare and social care services is significantly higher among older people. Research and reports show that the older people (especially those aged 75+) are the highest users of both NHS and social care services, due to the higher rates of chronic illness, mobility issues, and cognitive decline. For example: the Age UK report on aging in 2020 found that 45% of people aged 85+ receive both NHS health services and social care services, including home care or residential care. Data from the Carers UK report (2019) indicates that a significant proportion of older adults (65+) require social care alongside regular NHS health care, often due to issues like dementia, frailty, and stroke recovery.

APPENDIX 2: THE PRIMARY FACTORS CONTRIBUTING TO DELAYED DISCHARGES FROM HOSPITAL

Lack of available social care Services

- *Home Care Availability*: One of the most common reasons for delayed discharge is the insufficient availability of home care services. After a hospital stay, many patients require support at home, such as help with personal care (e.g., dressing, bathing), medication management, or mobility assistance. If there is a shortage of home care workers or if local authorities face budget constraints, patients may be unable to return home as planned.
- *Residential or Nursing Care Places*: Some patients, particularly older individuals or those with complex care needs (such as dementia or physical disabilities), may require placement in residential care or nursing homes. If local care facilities are full or there are delays in arranging the right care setting, it can result in delayed discharge.
- *CQC analysis*: The CQC State of Care Report for 2023/24 says that in April 2024, waits for care home beds and home-based care accounted for 45% of delays in discharging people who had been in an acute hospital for 14 days or more, with nearly 4,000 people delayed on an average day. Although some of these delays will have involved waits for health rather than social care services, the CQC say that social care is likely to have been a significant factor in these delays.

Funding and budget constraints

- *Local Authority Budget Cuts*: Over the past decade, local government funding for social care has been significantly reduced, leading to cuts in services and staff. This has created delays in assessments, care package provision, and overall capacity to meet demand.
- *Private Sector Constraints*: Many home care services and care homes are provided by private companies, and there may not always be enough providers in the area to meet demand, especially during periods of high need or in rural areas.

Complex needs and assessment delays

- *Delayed Needs Assessments*: Patients who require social care services need to undergo assessments by social workers or care coordinators to determine the level of care required. Delays in completing these assessments or waiting for a care plan to be approved can cause delays in discharge, particularly for patients with complex needs (e.g., those requiring multi-disciplinary support).
- *Multiple Stakeholders Involved*: Some patients, particularly those with long-term conditions, mental health problems, or disabilities, need coordination between multiple agencies (healthcare services, local authorities, housing providers, etc.). Delays in communication between these agencies or difficulties in organizing the appropriate care can cause discharge delays.

Workforce shortages

- *Shortages of Care Workers*: The social care sector has been facing severe workforce shortages, exacerbated by the COVID-19 pandemic. There is often a lack of trained care workers to deliver the care needed for patients to be discharged safely. This can include everything from personal care to more specialized services like rehabilitation.
- *NHS Staff Shortages*: In some cases, NHS staff shortages (e.g., social workers, physiotherapists) can also delay discharge. A lack of staff to conduct assessments or provide post-discharge support can result in prolonged hospital stays.

Patient or family preferences

- *Disagreements or Delays in Decision-Making*: Some patients or their families may be unwilling to accept the proposed care arrangements, especially if there are concerns about the quality of care, the location of a care home, or the type of care package. Negotiations or changes in care plans can delay discharge.
- *Housing Issues*: Some patients may need to be discharged to a new home or adapt their current home to meet their care needs (e.g., installing ramps, aids, etc.). Problems with finding suitable accommodation or making the necessary home modifications can contribute to delayed discharge.

Poor coordination between health and social care

- *Lack of Integrated Care*: The NHS and social care services are often criticized for working in silos, with poor coordination between health providers and social care services. A lack of integrated care pathways can mean delays in arranging discharge, as medical teams, social workers, and community care providers may not be aligned on discharge planning or post-discharge care needs.
- *Discharge Planning Delays*: Inadequate or delayed discharge planning can also lead to patients remaining in hospital longer than necessary. In some cases, discharge plans may not be initiated early enough, and there may not be a clear understanding of the patient's needs post-discharge, leading to last-minute arrangements that cause delays.

Capacity issues in the NHS

- *Overcrowding and Bed Pressures*: Delayed discharges can be exacerbated by pressure on hospital beds. If hospitals are already running at or near full capacity, there may be limited options for discharging patients who are medically ready to leave but still require social care support. In these situations, patients may have to remain in hospital while waiting for a suitable care package or placement to become available.