The King's Fund

Ideas that change health care

Written submission

The King's Fund's response to the Health and Social Care Select Committee inquiry on social care: funding and workforce

The King's Fund is an independent charity working to improve health and care in England. We help to: shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate.

We have wide experience in research and analysis of adult social care in England. We retain a positive vision of social care supporting people of all ages – working age adults and older people – to live the lives they want and be actively involved in their communities and wider society. We believe that reform should work towards this vision, recognising the diverse nature of the sector and the differing abilities and needs of people using adult social services.

We have confined our evidenced to the terms of reference and questions provided by the committee but we think it critical to recognise that the need to examine social care through a much wider lens than impact on the NHS. Adult social care adds much more value to the economy and society than can be seen through this narrow field of vision. However, we do believe there is much of value in adult social care from which the NHS can learn – for example, the sector's strong (albeit imperfect) focus on user involvement in services, community engagement and partnership working with health and housing organisations, including those in the voluntary sector.

What impact is the current social care funding situation having on the NHS and on people who need social care?

Though spending on adult social care has increased from a low point in 2014/15, in real terms the current level of expenditure is still below the 2010/11 level and does not reflect increases in population and levels of demand (Bottery and Babalola 2020c). This has led to the following consequences.

- **Unmet need:** Though more people now approach local authorities to request help, fewer get it. The key trend has been a continuing fall in the number of older people receiving long-term care – down 7 per cent (around 37,000 people) since

2015/16, despite an increase in the older population of nearly 468,000 over that period (Bottery and Babalola 2020a). This is a long-term trend, with evidence that eligibility thresholds were being raised even before austerity began. People in the most deprived areas are likely to have been most affected: 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 (Phillips and Simpson 2018).

- **Disruption of services:** Though the fees paid by local authorities for publicly funded clients have in recent years been increasing faster than inflation, they remain at levels that result in providers going out of business or handing back contracts, which in turn can lead to disruption or lack of supply for people needing care. This also affects provision of residential care because it creates more incentive for providers to build new homes in areas with larger numbers of self-funders (Bottery and Babalola 2020d).

- **Workforce problems:** Provider fragility has also led to care worker pay becoming more uncompetitive with other sectors, and this in turn has led to a growing number of workforce vacancies in social care. In 2012/13, the average hourly rate for sales assistants in the retail sector was £6.80 (below social care), but in 2018/19 it was £8.20, above that of social care (Bottery and Babalola 2020e). In 2018, the percentage of vacant social care posts was 7.8 percent (122,000) compared to 5.5 percent in 2012/13 (Bottery and Babalola 2020e). Despite these increasing problems in social care, there remains no long-term workforce strategy.

- **Disjointed care:** The fundamental barriers to joined up care between health and care are often cultural and organisational but they are compounded by aiming to join up one system that is free at the point of use with another that has an increasingly restrictive means test. This causes delay and inefficiency in both systems (evidenced most obviously in delayed transfers of care) and confusion and distress for users of services. There is also evidence that better joint working between primary, community, acute and residential care providers has the potential to reduce accident and emergency attendance and emergency admissions (Wolters *et al* 2019).

- **Quality issues:** While the satisfaction of publicly funded clients with the services they receive has been consistent for several years, there is evidence of increasing concerns among the people who care for them. A biennial survey of family carers finds only 39 per cent satisfaction with services received by themselves and the people they care for (NHS Digital 201b). One explanation for this is that, in the face of the decline in publicly funded care, carers are having to do more. Moreover, there is now less local authority support for them: the number of people supported by local authorities has fallen and less money is being spent on carers than in 2015/16 (Bottery and Babalola 2020e).

- **Falling investment in prevention**: Underfunding has also meant that cash is increasingly focused on supporting those in greatest immediate need rather than preventing need from arising in the first place. This is directly opposite to the intent of the 2014 Care Act, which stressed the importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist. Yet in 2015/16 local authorities spent £233 million on information and early intervention but by 2018/19 even this small amount had fallen, to £205m (in cash terms). Similarly, spending on assistive equipment and technology had fallen from £207 million to £205 million (in cash terms) (NHS Digital 2019a). The percentage of over-65s leaving hospital who received reablement, which has an established record of improving abilities, also fell between 2015/16 and 2018/19, and capacity is estimated to be around half of the level required (Bottery and Babalola 2020b).

- **Cost unfairness:** The reduction in the numbers accessing publicly funded care means more people are required to pay for their own. They then face a double unfairness. Firstly, around 1 in 10 will face catastrophic costs of more than £100,000 and have no way of protecting themselves against these costs. Secondly, privately paying clients effectively subsidise the fees of publicly funded clients: in 2017 the Competition and Markets Authority estimated that care home fees paid by local authorities were 41 per cent below the prices paid by self-funding clients (Competition and Markets Authority 2018).

What level of funding is required in each of the next five years to address this?

In its separate submission to this enquiry, the Health Foundation has suggested a figure of between £2.1 billion and £12.2 billion by 2023/24 for scenarios that range from simply meeting future demand to one that returns to the access and spending levels in 2010/11 and also increases pay (Health Foundation 2020). While we do not necessarily share all assumptions in each scenario, we believe this range is a reasonable starting point for a discussion about funding requirements, though we note, as does the Health Foundation, that the impact of Covid-19 is still largely unknown. The 'new' baseline in terms of demand for services, access levels, costs of delivery, etc is impossible to quantify at the moment.

We also caution against starting with a funding estimate to 'patch up' the current system and instead suggest an approach that – while accepting there can be no blank cheque for social care reform – outlines the key aspects of the social care system that England needs and considers how best to fund them over the long term. It is essential that the underlying foundations of social care are never again left exposed as they have been by the Covid-19 epidemic. We outline the basic elements of reform in our response to the final question in this consultation.

What is the extent of current workforce shortages in social care, how will they change over the next five years, and how do they need to be addressed?

In April 2019, there were around 122,000 vacancies in social care (7.8 per cent of the workforce, compared to 5.5 per cent in 2012/13) (Bottery and Babalola 2020e). This is a worsening situation has been driven by the reducing competitiveness of care worker pay. Despite legally required increases resulting from the national living wage, pay in the sector has fallen behind wage levels of occupations such as cleaners and shopworkers. It is also well below similar roles in the NHS – in 2018/19 a health care assistant might expect to earn between £8.93 and £9.57 per hour, compared to an average of £8.20 for a care worker in social care (Bottery and Babalola 2020e). There has also been a compression of pay bands in social care, with experienced staff now earning only £0.15 an hour more than new starters (compared to £0.37 in 2013) (Bottery and Babalola 2020e). The independent companies that provide most social care services, have found themselves caught between the legal demands of the minimum wage (which continues to increase), the need to remain competitive with other sectors and the low fee levels paid by local authorities.

In light of Covid-19, it is very difficult to predict workforce levels in the short to medium term. Historically, the trend in demand for care workers has followed the growth in the over-65 population in England (though in reality the drivers are clearly more complicated since around half of expenditure and a sizeable proportion of the workforce supports working age adults rather than older people). Clearly, tragically, the size of the over-65 population will be affected by the Covid-19 epidemic and this may reduce demand. The closure of businesses and furloughing of staff in other business sectors has also meant an increasing pool of labour for social care with some care providers now reporting record numbers of applications for vacant posts. An economic recession, which is widely predicted, is likely to have the same effect. Vacancies in the short to medium term may fall, therefore. However there are question marks around capacity to train and develop these staff, and around their longer-term retention, which in turn raises concerns about increases in the already very high rates of staff turnover (in worst affected roles, such as homecare workers, nearly half of staff leave their roles in a year, with obvious impact on quality.)

Beyond this, however, it is likely that the historic trend of growing workforce demand but increasing vacancies will recommence unless there is fundamental change in the social care market. An accelerating factor may be the changes to UK immigration policy and the end of free movement of labour from EU countries. EU migrant workers make up 8 per cent of the social care workforce in England (a larger percentage in areas such as London) (Skills for Care 2019) and, in the absence of a visa route for social care staff, this can be expected to fall as some existing staff either retire, move sectors or leave the UK entirely.

There is no simple solution to this entrenched workforce problem. A critical factor is pay but staff are employed by a diverse, heterogeneous industry with around 20,000 separate providers, who are competing for business from 150 price-sensitive local authorities (as well as 211 clinical commissioning groups, who buy care as part of NHS Continuing Healthcare Packages, and around 350,000 self-funders). There are also around 110,000

self-employed social care personal assistants (Skills for Care 2019). There is therefore no simple way of improving staff pay and conditions sector-wide. There are options worth exploring, such as a sector-specific minimum wage, but improvements in pay and conditions should ideally be linked to improvements in training and service quality, which suggests that pay should be considered one factor in the much wider-reform of social care rather than a standalone issue. This reform should see the health and social care as two closely intertwined sectors and develop career pathways between the two, with a workforce strategy that considers both sectors (at the moment, a people plan is under discussion for the NHS but not social care).

What further reforms are needed to the social care funding system in the long term?

We have argued that the several key areas for reform in social care and that genuinely long-lasting reform must involve a comprehensive programme of measures, introduced over time, rather than a single headline policy in isolation. It must address issues affecting working age adults (on whom half of all expenditure is currently spent) as well as older people. Funding reform alone will not fix the many problems in social care but it is important to have clarity on the funding model to get more money into the system and given long term certainty to those providing social care. The key areas for reform are outlined here.

1. **Increasing access to publicly funded social care**: It is essential to provide free or subsidised care to more people to ensure greater equity of access to services and reduce friction between the health and care systems. This should include those with less intensive needs to maximise prevention. To avoid catastrophic costs, increased access will most likely need to be supplemented with a cap on individual care costs.

2. **Improving quality of care**: Co-ordinated, concerted action at national and local levels to improve effective leadership, culture, regulation and staffing in social care.

3. **Better workforce conditions and development**: improving pay, conditions and training in the sector has to underpin wider reform, otherwise there will simply not be enough care workers to deliver the quality of care people expect and meet increases in demand for care in the future. This will be hard to achieve in a diverse sector, so legislation and regulation may be needed. There is also a need for more work to promote the image of the sector.

4. **Strengthening the market**: Local authorities are the key players in local care markets. Improved commissioning, including an increase in the amount paid for care, is likely to be the most effective way of restoring market strength, but in some areas some services may need to be brought in-house by local authorities to tackle service gaps.

5. **Joining up care**: Better integration of health and social care (as well as housing and other sectors) has the potential to improve people's outcomes and experiences, particularly for the growing number of people living with multiple long-term conditions. Integrated care systems offer an opportunity to turn rhetoric into reality but will need to fully involve local authorities as equal partners. Changes to system eligibility, technology and integrated budgets can also help but much rests on the quality of relationships between local leaders and their organisations.

6. **Reducing unwarranted variation in access and quality:** Responsibility for services should remain with local authorities, recognising the importance of their links with the local community and local health care services. But we need fairer distribution of national funding and more national focus on performance, spreading the success of areas that are succeeding and supporting those that are not.

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