KREAB WORLDWIDE *briefing*

SOCIAL CARE SECTOR

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insight

SOCIAL CARE BRIEFING NOTE

This briefing note was prepared for Kreab and outlines key issues facing the care sector.

POLICY

Councils have responsibility in law for ensuring that there is a market for care in their area which is sufficient in volume and quality for their local population.

Unlike the NHS, social care is highly means-tested and individuals with assets of over £23,250 must pay for their care, much of which they buy directly from care providers.

Social care policy has developed over the last century from a one-size-fits-all ethos underpinned by the Poor Law to a much more individualised and rights-based approach. 'Person-centred' care is intended to maximise the choice and control that the person has over their support. Since the 1990s, the policy has been to support people to stay in their own homes. This is considered to be better for the individual and cost-effective for the state.

Social care services are commissioned by local authorities from operators who range in size from small charities to large corporate bodies. Councils have responsibility in law for ensuring that there is a market for care in their area which is sufficient in volume and quality for their local population. There is a recognised cross-subsidy between private payers and local authorities with private individuals systematically paying more for services than people who are funded by the state[1].

Integration between social care and health is regarded as desirable in policy terms; however, the differences between the way the two systems are governed and funded makes true integration unlikely without a fundamental change in the division of responsibilities between the NHS and local government.

[1] Department of Health & Social Care

UNMET NEED

The funding for social care has not kept pace with the growing demand for support from both older people and younger disabled adults in the population. Age UK calculates that 1.6 million people aged over 65 are experiencing unmet need, waiting for assessment from a local authority or not getting any help.

Over 2,000 learning disabled people are detained in in-patient units, 16% of them detained for over 10 years. Ref MENCAP.

A significant number of people with a learning disability or autism are being inappropriately confined in mental health facilities, as opposed to being supported to live in their own homes. This is despite a government programme called 'Transforming Care', intended to facilitate the discharge of patients into community services closer to home, that was initiated in 2012 in response to the mistreatment of individuals at Winterbourne View Hospital.

WORKFORCE PRESSURES

Staff shortages create more pressure on the remaining employees and, perceiving themselves to be carrying more risk, they are more likely to leave or burn out.

The number of people working in adult social care is estimated at 1.54 million (as opposed to 1.4 million working in the NHS). 74% of those jobs involve directly providing care. A significant proportion of care workers are paid the minimum wage. Over 80% of all care jobs done by women, although there are more males in senior roles.

At 28.5%, turnover is higher in social care than other occupations. At the time of writing, there were 105,000 vacancies in social care.

In 2021, 84% of workers identified as British, 7% as EU nationals and 9% as non-EU. From January 2021, new immigration rules came into place that effectively meant people could not come into the UK to take up care worker roles. In December 2021, care workers were placed on the shortage occupation list for 12 months.

Since November 2021, it is mandatory that anyone entering a care home in a work capacity is vaccinated against COVID-19.

Currently, there are more unfilled jobs in social care than before the pandemic, with an estimated 60,000 workers leaving in the last 6 months. Following on from the impact of Brexit, burnout from the pandemic, compulsory vaccination and the prospect of more attractive wages in other sectors, 90% of operators are struggling to fill posts. Care workers are generally paid the minimum wage despite performing a skilled role at least on a par with NHS Healthcare Assistants, who receive 7% higher pay. Staff shortages create more pressure on the remaining employees and, perceiving themselves to be carrying more risk, they are more likely to leave or burn out.

NHS Providers estimate between 20% and 25% of people in hospital currently are medically fit for discharge but have nowhere to go Ref BBC

Due to the staffing shortage, a number of care homes are reportedly not taking in new residents while others are declaring 'unsafe staffing levels'. Similarly, many home care agencies are unable to take on new work or fulfil existing contracts. The shortage of available care impacts on healthcare in the NHS.

Councils are struggling to fill vacancies for qualified Social Workers and, according to the Association of Directors of Adult Social Services, the resulting shortage of social care professionals is putting older and vulnerable people at risk.

VALUE AND PERCEPTION

Hands-on care is largely characterised as female segregated employment, attracting low wages and widely perceived as low value. This is linked to the fact that women working in care are providing services that many other women are expected to provide for free within the family. Women are more likely to exit the labour market to become unpaid carers. More women than men are recipients of social care, 58% of the publicly funded care population is female. Women live longer with disability and as they outlive men, they are less likely to receive informal care. Women are more likely to be living in care homes, with some services reporting up to 80% female occupancy.

Nearly half of all deaths from COVID-19 in the developed world occurred in long stay facilities Ref Nature Ageing.

Care homes were receiving bad press before the pandemic, with negative stories peppering the media and little recognition of the role they play in helping people to live a happy life or experience a good death. A slow government response to the risks faced by people living in care homes from COVID-19 resulted in a significant number of well-publicised deaths. Subsequently, and probably reacting to this earlier lack of action, people living in care homes are now subject to restrictions on their liberty which has increased the reluctance of individuals to move into a care home unless absolutely necessary.

SUPPLY AND DEMAND

The number of care home places per 100 people over the age of 85 has fallen from 33.7 to 28.7 since 2010 and is forecast to fall further.

As more people live longer with diseases such as dementia, the demand for social care is going to increase, however, the number of care home places is stagnating or even decreasing. The longer-term prospects for care operators are good, but the pace of development is not keeping pace with population growth. The number of care home places per 100 people over the age of 85 has fallen from 33.7 to 28.7 since 2010 and is forecast to fall further. The main reasons for closure are failing care standards and financial stress, the latter brought about by increasing staff and other costs and systematic underfunding of fee rates by local authorities.

The domiciliary care market is expected to grow by 6.5% by 2026.

Despite a short-term fall in occupancy caused by the pandemic, old and unsuitable buildings will put extra pressure on capacity in the medium term. Of the UK's care home stock, an estimated 70% is now aged 20 years or older. Estimates suggest, at current rates, it will take several decades to fully modernise care homes.

REGULATION

Overall, in 2020, CQC rated most care as being ‘Good’.

The provision of personal care is highly regulated in England by the Care Quality Commission (CQC). Personal care is defined in legislation[2] and covers intimate tasks such as washing, dressing and eating, or prompting to do the same. In most circumstances, it is illegal for a person to be paid for providing personal care without being registered with CQC (self-employed care workers are exempt). Any operator who delivers personal care in the community, termed domiciliary care, or in a care home, has to register with CQC, pay a fee, and submit themselves to inspection of their services.

CQC inspects against 5 criteria and produces ratings that must be publicised by the care provider as follows: Outstanding, Good, Requires Improvement and Inadequate. They can take enforcement action when care falls below standard or does not improve fast enough, including the removal of registration (closure), prosecution and the issuing of fines. Overall, in 2020, CQC rated most care as being ‘Good’.

In England, 5% of services were ‘Outstanding’, 80% ‘Good’, 15% ‘Requires Improvement’ and 1% were rated ‘Inadequate’ Ref CQC

In England in recent months, the CQC has adopted a new risk-based monitoring approach that relies on information already held on services and/or responding to complaints or whistleblowing concerns. These targeted partial inspections are leading to a disproportionate emphasis on negative aspects of service, with inevitably lower ratings. Up to 50% of inspections are resulting in a Requires Improvement or Inadequate rating. Furthermore, many operators have hugely out-of-date ratings that do not reflect the true position within a service, making it difficult for the buying public to judge the quality of provision.

In a recent webinar to care providers, the CQC made strongly worded comments that they would not be complicit in the provision of unsafe care and could not make allowances for providers unable to recruit sufficient safe numbers of staff. Most poor outcomes reflected in recent inspection documents are in some way linked to staffing issues, from concerns about over-stretched staff making mistakes through to criticism of high turnover resulting in lack of continuity of care. Rarely have inspection reports made any concession to the challenges of the pandemic or mention that providers are facing the worst staffing crisis in decades.[3]

[2] Health and Care Act 2008
[3] Anthony Collins Solicitors

IMPACT OF COVID-19

COVID-19 has amplified many of the issues that already existed in social care.

38% of home care providers have handed back contracts for care to local authorities Ref Homecare Association.

COVID-19 has amplified many of the issues that already existed in social care. Self-isolation has exacerbated feelings of loneliness and accelerated the deterioration of older people living both at home and in care homes (due to restrictions on social contact). A significant number of deaths occurred in care homes early in the pandemic. This intensified the negative perception of care homes and resulted in a drop in occupancy that has put many operators under financial strain. Following years of underfunding and low margins, the sector was not resilient enough to withstand the impact of the pandemic. COVID-19 has worsened the workforce shortage and existing supply and demand issues, with many operators either handing back contracts to local authorities or even going out of business.

RAPIDLY CHANGING DEMOGRAPHICS SUPPORT THE NEED FOR CARE

In 2020 there were million people aged over 85, by 2050 it is projected there will be 3.7 million Ref ONS.

Demand for care is increasing as the demographics in the UK population change. There are currently 12.7 million people aged over 65 and the proportion aged over 85 is set to double over the next 25 years.

There are more women than men in older age. Average life expectancy for a man is 79, for a woman it's 83, although the gap in longevity is narrowing. The gap in life expectancy between the least and most deprived areas in England is 9.5 years for men and 7.5 for women[4].

18% of care home residents pay for their own care in the Northeast of England compared to 54% in the Southeast Ref Laing&Buisson.

Whilst it is not universal, the prevalence of poor health and life-limiting conditions tends to increase with age. For example, dementia affects 1 in 14 people aged over 65 but increases to 1 in 6 people aged over 80. There are currently 900,000 people living with dementia in the UK, predicted to rise to 1.6 million by 2040[5]. Definitive numbers of older people who pay for their own care are not available; however, they account for approximately 45% of people living in care homes[6].

Approximately 300,000 people aged 18 – 64 receive long-term support. Currently, just under half of the money spent by local authorities on social care funds support for younger adults, 70% of whom have a learning disability. Requests for support from those aged 18 – 64 increased from 500,000 in 2015 to 560,000 in 2021, reflecting higher levels of disability in the population[7]. Younger disabled people, especially those needing specialist learning disability or mental health care, are much less likely to pay for their own care.

According to the Census, in 2011 there were 5.4 million carers in England (10.2% of the

[4]Office for National Statistics (ONS)
[5] Alzheimer's Society
[6] Business wire
[7] Kings Fund

population) but the Charity Carers UK puts the figure higher at 7.3 million, or 18% of the population. 1 in 4 older female employees and 1 in 8 older male employees have caring responsibilities[8].

PROVISION OF SERVICES

The care market is very fragmented. The top 10 largest care home operators have a 22% market share.

People known to local authorities with a learning disability predominantly live with family (38%), care homes (22%) or supported housing (28%) Ref MENCAP.

The number of adults receiving care in 2021 was 890,000. In the UK, there are 17,000 organisations delivering social care in 39,000 locations. There are 17,600 care homes, approximately 11,000 of which are registered for older people. Approximately 420,000 people live in care homes. This is 4% of the total population aged 65 years and over, rising to 15% of those aged 85 or more[9]. There are 8,000 registered domiciliary care providers. In 2019, there were 730,000 people living in retirement housing[10], not all of whom will require care. There are approximately 50,000 units of extra care housing.

The care market is very fragmented. The top 10 largest care home operators have a 22% market share. Overall, 74% of care home providers run just one home. The majority of care homes are privately owned, 14% are not-for-profit and 10% are run by local authorities or the NHS. Domiciliary care is similarly characterised by a large number of small providers with 90% operating from one location[11].

The economic value of the social care market in 2021 was estimated at £50.3 billion, made up of £25.6 billion GVA and the rest being indirect effects. Net local authority expenditure on adult social care in 2021 was £16.5 billion[12]. The average weekly fee rate for older people's care homes is £949. The home care market is estimated at £9.5 billion. 70% of home care is purchased by councils, who pay an average of £18.45 per hour. This is below the minimum hourly rate recommended by the Homecare Association of £21.43 necessary to cover wages, supervision, travel time, insurance etc[13]. The hourly rate of home care paid by private individuals is between £20 and £30 per hour. Live-in care can be sourced for between £900 and £1,400 per week[14].

[8] ONS 2019
[9] Laing & Buisson
[10] Elderly Accommodation Council
[11] Laing & Buisson
[12] National Audit Office
[13] Homecare Association
[14] Homecare.co.uk

INNOVATION IN CARE

Village Agents, social prescribing and daytime discos are examples of initiatives deployed to promote wellbeing and to prevent people from needing care in the first place.

Examples of innovation in the sector can be found but due to fragmentation in commissioning and provision they are rarely scaled up. Alternatives to care homes comprise retirement housing with care on-site, including care villages dedicated to people living with dementia. 'Shared Lives' is a form of adult fostering. 'Homeshare' involves older homeowners offering accommodation in return for companionship and low-level support.

In domiciliary care, outcomes-based commissioning, self-managing Wellbeing Teams and 'Buurtzorg' style nurse-led models of support at home have all been tried, to improve the effectiveness of the help provided, and to move away from task-based care.

Assistive robotics that help with personal care, such as dressing, and holograms that create a virtual consultation with a carer or a GP are in development.

Village Agents, social prescribing and daytime discos are examples of initiatives deployed to promote wellbeing and to prevent people from needing care in the first place.

A variety of assistive technology is currently in use, much of it to enable remote monitoring, intended to enhance independence and reduce risk. Telehealth provides remote diagnosis, treatment and the opportunity for self-management of health and care issues. Social robots in the form of animals or mini humans can provide companionship.

CHRONIC UNDERFUNDING

The Health Foundation thinktank has calculated that funding for social care needs to increase by £4.8 billion a year to stabilise the system and £9.3 billion a year to enable it to recover Ref Health Foundation

Many of the issues affecting social care are the result of chronic underfunding, with the DHSC acknowledging that fee rates paid by councils do not cover the real cost of care. Lack of funding has resulted in a lack of investment, workforce pressures and a failure to innovate in the sector. The cross-subsidy between private payers and publicly funded people is not only unfair but leaves some individuals facing catastrophic care costs through no fault of their own. Lack of funding for services that prevent deterioration means that, by the time they receive help, people are in a worse condition than before and their care costs are higher.

In the past 5 years, the combination of an ageing population and government cuts has effectively wiped out 31% of the council social care budgets across the UK.

SOCIAL CARE REFORM

Despite repeated warnings about the critical state of the sector, the broader funding of adult social care has not been addressed.

In order to address the potentially unlimited care costs faced by individuals, the government plans to raise National Insurance and a tax on dividends of 1.25% from April 2022. These will be hypothecated to fund health and social care and are expected to raise £36 billion over the following three years. A new £86,000 cap on the amount anyone in England will have to spend on their personal care over their lifetime will be introduced in October 2023. Only money spent on meeting personal care needs will count towards the cap. Spending on daily living costs (care home 'hotel costs') will not count. At the same time, the means test for accessing local authority funding will be made more generous, with the upper capital limit increasing from £23,250 to £100,000.

Unfortunately, the reforms will help relatively few people as most won't ever reach the cap. Questions on whether the funding provided will be sufficient to address the wider issues in the sector and the challenges associated with transferring revenue raised by the NI levy from the NHS to social care in future years add to the uncertainty. This uncertainty about future funding and care policy means providers are reluctant to invest in the additional capacity needed. For example, current funding for new investment in accommodation for adults with care needs is ad-hoc, with no coordinated long-term vision across government about how to fund or incentivise the market through mechanisms such as fee rates, housing benefit, grants or loans. Despite repeated warnings about the critical state of the sector, the broader funding of adult social care has not been addressed.

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