National Care Forum Submission to the Public Accounts Committee Call for Evidence on the Adult Social Care Markets – April 2021

National Care Forum

Who are we?

The National Care Forum (NCF) is the membership organisation for not-for-profit organisations in the care and support sector. NCF supports its 130 members to improve social care provision and enhance the quality of life, choice, control and wellbeing of people who use care services. We are the voice of the not-for-profit care and support sector. Our members:

- ✓ Provide care and support to around 170,000 people
- ✓ Operate over 9200 services
- ✓ Provide more than 45,000 care home places
- ✓ Employ over 93,000 staff & some 13,500 volunteers

1. Social care matters

1.1 The Coronavirus pandemic has placed enormous pressures on a sector which was already in a state of crisis prior to Covid-19 and which is in desperate need of fundamental reform.

1.2 A broader point for the context of this inquiry and the current picture of the adult social care market is that we urgently need the government to lay the foundations for social care reform and to invest in social care to ensure that it sustainable in the long term, maximises its contribution to national economic recovery and plays a key role in ensuring that all people with care & support needs are supported to live the best lives they can in the way that they want and are fully included in their communities. As Social Care Future puts it[1],

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

1.3 Social care matters to the millions who need it, the 1.5m strong workforce and the 25,000 organisations providing it.

Key considerations for the call for evidence:

- How Adult Social Care is currently provided and structured
- DHSC's effectiveness in overseeing the market & holding providers to account; its understanding of future demand, costs and alternative delivery models
- The impact of COVID on the market and the sector's financial sustainability

[1] https://socialcarefuture.blog/

How ASC is currently provided and structured

2. The recent National Audit Office (NAO) report on the adult social care market in England[2] provides a helpful overall summary of the large and diverse picture of the adult social care sector:

Around 14,800 registered organisations provide care across 25,800 locations. In addition to these there are an estimated 3,800 non-Care Quality Commission (non-CQC) registered locations which offer residential services and 8,500 non-CQC registered locations which offer non-residential services. The top 10 providers of care homes and care at home have small market shares. Based on revenue, LaingBuisson estimates the market share of the 10 largest care home providers for older adults is 22% and the market share of the 10 largest care at home providers is just 16%. There are large numbers of small providers. Overall, 75% of care home providers run just one home, accounting for 38% of total beds; 90% of care at home providers operate from one location.

Independent providers run most care homes; based on market value, 76% of care homes for older adults and adults with dementia are for-profit. Of the remaining 24%, 14% are not-for-profit and 10% are run by a local authority or the NHS.

The value of a diverse adult social care market

2.1 As the above indicates, there is a wide range of care and support services that currently exist to support people who require care and support including:

- residential care and nursing homes
- extra care housing
- care at home and live in care
- supported living and supported housing
- personal assistants
- community based services and day services
- family carers and unpaid carers

National Care Forum members operate over 9200 services, supporting over 170,000 people via a wide range of the types of care and support services listed above

2.2 We can testify, on behalf of our members who provide these services and the people they offer care and support to, just how important this diversity is, so that care and support can be tailored to meet the needs and choices of the individuals being supported, provided where, when and how they need it, rather than being constrained by local authority commissioning and funding pressures. Person-centred care in service design is essential but too often this is not co-created with the people who need it and the providers who offer it.

[2] Paragraphs 1.21 & 1.22 https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf

2.3 As the voice of the not-for-profit part of the adult social care sector, NCF believes that the not-for-profit model offers greater transparency in terms of governance, finances and accountability, as well as being values-focused. The not-for-profit organisations we represent place a strong emphasis on the long term sustainability of their care and support services in the local communities they serve, often having deep roots due to their origins and history in local areas, alongside their focus on person-centred care.

2.4 Many of the not-for-profit organisations providing care and support are charities or social housing providers, meaning they are not just accountable to the CQC but also the Charity Commission and the Social Housing Regulator. As a result, the organisations we represent, by their very nature, have a very strong culture of accountability, governance, diversity and person-centeredness.

2.5 Not-for-profit care provision ensures that all of the funding from either government or citizens is directed towards the sustainable delivery of high quality care and innovation, both now and in the future. There is a real opportunity for Government policy around funding and reform to recognise the enormous potential for not-for-profit care in delivering greater returns to the communities that they serve and to look to incentivise this model of provision through both the reform and funding agenda. We strongly advocate more focus on supporting current commissioning and funding arrangements to recognise the benefits and social value of the not-for-profit sector, which will help to reinforce the legislative framework as outlined in the Social Value Act.

3. Unsustainably low funding for care, unmet need and inequality of access

3.1 As the NAO report and others before it makes clear, local authorities have the responsibility for the commissioning of care and support services in their local areas and for shaping their local care market offer. And, as the report also makes clear, the funding for local authorities to do this well has faced very significant cuts – the report finds that '*Government funding for local authorities in aggregate fell by 55% in 2019-20 compared with 2010-11, resulting in a 29% real-terms reduction in local government spending power (government funding plus council tax revenue*)' and that LA spending on care is also '*lower than in 2010-11 but has begun to rise compared with previous years*'[3].

3.2 These financial pressures can drive a wide range of poor commissioning approaches which result in unsustainably low levels of funding for care – shockingly, the NAO report found that '*For 2019-20 the Department assessed that the majority of local authorities paid below the sustainable rate for care home placements for adults aged 65 and over and below the sustainable rate for home care. The Department does not challenge local authorities who pay low rates'*[4]*.* The findings within the NAO report chime with research with our NCF members over recent months. In February 2021, our most recent NCF PULSE Survey found that local authorities do not seem be able to offer increases in

[3] Ibid, p.6.
[4] Ibid, p.8.

fee rates for 2021/22 that will go anyway near to compensate the costs of providers. Of those responding to the survey 28% had not yet been offered any fee rate increase and of the 39% that had, just under half of them had had an offer of an increase of less than 2.2% - this is well below the increase in the national living wage and does not leave room for other increases in costs for the coming year[5]. See also section 9 for more in depth work we did for the Spending Review in the autumn of 2020.

3.3 The NAO report also notes that the number of adults aged 65 and over receiving long-term support has actually fallen, despite the ageing demographic in our population, and that the data on unmet need is very patchy.

3.4 A recent report by NHS Digital gives a sense of the level of unmet need across all age groups.[6] The report is largely based on data from before the pandemic. It found that following an initial period of short-term support, a decreasing proportion since 2015 are going on to receive long-term support, even if they need it. Conversely, a higher proportion are receiving further short-term support instead or an early cessation of service. The number and proportion of older people receiving state-sponsored long-term care is decreasing. The largest decreases are seen for older adults being supported in the community. These trends also exist for those aged 18-64 but it is particularly pronounced in older adults. This data won't capture all the unmet need, as it doesn't include self-funders or others the LAs don't know about. It is the tip of the iceberg.

3.5 This all paints a very stark picture in terms of the ability of LAs to meet people's care and support needs, their ability to pay a fair price for care and the inequality of access to care when people need it most. Inevitably, commissioning often becomes very cost sensitive and cost focussed, sometimes at the cost of choice, control and the person-centred approach to care and support that we would all want for ourselves or our loved ones. The evidence we have gathered in our NCF PULSE surveys from our members in relation to the fees levels that local authorities are prepared to offer highlights just how significant the financial pressures are within the sector.

NCF ask: Investment to achieve a fairer system – a Fair Price for Care

3.6 We need a bold investment in social care to rebalance the fairness between the costs paid by individual people and the costs paid by the state, as well as identifying and meeting unmet need.

3.7 The current system puts a huge burden on those who need care and support and are able to pay for their own care and support under the current means testing arrangements. It is fundamentally unfair and creates a huge uncertainty and anxiety about the future costs

[5] https://www.nationalcareforum.org.uk/ncf-press-releases/vaccination-good-progress-but-more-to-be-done/
[6] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-statistics-in-england-an-overview/2020

people may incur and creates a complex system around costs of care at precisely the time when care is needed urgently, often because of a crisis.

3.8 This is exacerbated by the unofficial 'cross subsidy' effect faced by many people; those who fund their own care are paying higher levels of costs for their care because the state's commissioning approach is driving down the fees that the state pays for those who cannot afford to pay for their own care – this is resulting in an increase in costs for those who can. Analysis from the Kings Fund highlights that '*this cross subsidy can be significant: on average, a self-funder's place costs around 40 per cent more than one paid for by the local authority*.'[7]

3.9 The current unofficial 'cross subsidy' model means that individuals are paying a significantly higher price for privately funded care as LAs drive down the price they will pay for state funded care. This is deeply unfair and, as we are seeing now, increasingly fragile. As the National Care Forum, we are calling for a Fair Price for Care, to ensure that the true cost of care is paid by the state; this will enable not-for-profit providers to rebalance the prices paid by individuals, ensuring that there is one price for care for all.

3.10 Many others have rehearsed the different options for how to fund the additional long-term investment in social care, with their pros and cons. At the NCF, we believe it is important that the option chosen assures key elements of intergenerational fairness – the way we choose to invest in and pay for care and support (both now an in the future) must balance the burdens and benefits across the generations.

4. Encouraging New Models of Care

4.1 Current commissioning practices and market shaping rarely draw upon the diverse potential of the sector and the voices of both providers and those receiving care and support to shape future models. We, at the NCF, want to see commissioning practices which encourage innovation to develop new models of care – particularly in relation to the adoption of technology-enabled care and the creation of more housing-with-care. Technology-enabled care can give recipients of care more power and choice over their support as well as giving commissioners and providers the data necessary to improve the quality of care. The not-for profit sector is a leader in innovation and the use of digital technology as the not-for-profit model is a real enabler in terms of investing in new ways to improve the overall quality of the care and support we offer. Many of our NCF members have pioneered the use of new technology in their care settings and care services (see section 7 for more detail about the innovative digital project that we in the NCF ran called The Hubble Project, aimed at helping to boost the sector's digital maturity).

4.2 Innovation inevitably brings a degree of risk, which needs to be managed carefully between commissioners, care providers and the regulator, so we were delighted to work

[7] https://www.kingsfund.org.uk/projects/positions/adult-social-care-funding-and-eligibility

closely with CQC to produce their recent report entitled 'Enabling innovation and adoption in health and social care: Developing a shared view' which outlines 6 principles that are crucial for providers to be more effective at innovating[8]. As this report explains;

'*The NCF is a leader in supporting the care sector to embrace innovation in care delivery as well as digital technology to improve the quality of care for those using care services. They play a leading role in Digital Social Care, which is a joint Care Provider Alliance and NHS Digital project, run by social care providers for social care providers, offering a dedicated space providing advice and support to the adult social care sector on technology and data protection*'

4.3 In terms of housing, many of our NCF members offer housing services as part of their mixed service portfolio, often combining extra care housing alongside a wider community based domiciliary care offer as well as residential care settings. NCF was part of the Commission on the Role of Housing in the Future of Care and Support[9]. There were a number of important messages, which need to be considered when developing new models of care:

- **Better Choices:** Across the country, there is a lack of choice and availability of supportive settings to meet people's needs. The range of housing with care models is not consistently available to those who need them. We recognise that we need better housing choices for people to help them age well, and the quality, quantity of housing with care and support needs to be improved.
- **Increased Investment:** We need to develop innovative models of housing with care and support that are in the right place and that promote independence. This will require an increase in capital spending. We also need to create better incentives to encourage developers to invest in housing.
- **Planning Reform:** We need to reform the planning system. It is harder to build retirement community housing compared to care homes, as they are not currently defined within the planning system. We need a clear regulatory framework for retirement communities to implement sector-specific legislation on regulations and standards.
- **Empowering Individuals:** We need to put power into the hands of the consumer. We can do this by offering better information, advice and advocacy for those who require housing that facilitates care and support. We need to work together, involving people who use services to plan and design, new and existing housing that facilitates care and support.
- **Working Together:** We need a joined-up approach to commissioning involving care homes, housing, housing developers and health and social care – working in close and equal partnership, connecting social care to wider housing and infrastructure.
- **Technology Matters:** Technology can improve the lives of people living in housing with care and support. COVID-19 has accelerated the take-up of new technologies in

[8] Enabling innovation and adoption in health and social care: Developing a shared view
[9] Commission on the Role of Housing in the Future of Care and Support

care settings and demonstrated how liberating technology can be. Developing new forms of housing with care and support that feature useful technology has the potential to enhance care experiences and outcomes.

4.4 The government, local authorities and the wider care sector need to be thinking about how we can shape markets to achieve the necessary levels of staff and care as well as what the customer of the future will want and need from any care and support – sticking with the status quo is not an option.

5. The social care workforce

5.1 Our society is facing demographic challenges that have a real impact on social care. Skills for Care has shown that the population aged 65 and over is projected to increase between 2020 and 2035 from 10.5 million to 14.1 million. This means that the adult social care workforce will need to grow by at least 32% by 2035[10]. However, Skills for Care has also shown that there are currently 112,000 vacancies in the sector. We cannot continue like this. Our NCF members employ over 93,000 staff across a wide range of care and support services within social care and as not-for-profit organisations they have consistently been strong advocates on behalf of their amazing workforce.

5.2 The NAO report has a clear recommendation that the DHSC '*develop a workforce strategy in line with its previous commitments, to recruit, retain and develop staff, aligned with the NHS People plan where appropriate'*[11]. It notes that stakeholders have consistently '*identified the need for central leadership to improve pay and conditions for care workers, and to incentivise improved training and development*'. We absolutely support this. Public perception polling that the NCF carried out in the summer of 2020 found that three quarters (74%) of adults in England believe care home staff do a brilliant job. It also shows an overwhelming belief that care workers are undervalued (81%) and 80% of adults in England believe that care workers should be paid better.

NCF ask: **Invest in the workforce to create a professionally skilled workforce, properly valued, better paid, with more training and development.**

5.3 Investing in social care also means investing in the workforce. This will bring a range of strong economic and quality benefits as well as enabling social care employers to pay social care workers what they are actually worth. In one of our recent PULSE surveys[12], we explored the immense pressures that COVID-19 has placed on the immense on the care workforce and the way in which NCF care providers have responded. The ethos of the not-for-profit employers shone through in the wide range of wellbeing initiatives they have implemented to support their staffs' mental health and wellbeing, from

[10] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf

[11] https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf p 12. Ibid, p. 56.

[12] https://www.nationalcareforum.org.uk/ncf-press-releases/a-stretched-and-underfunded-sector/

setting up dedicated counselling and employee assistance programmes, to the introduction of mental health schemes (typically Mental Health First Aiders) to enhanced 1:1 and financial support.

5.4 Great care needs great people to provide it. Investment is essential to create a dedicated, fully funded People Plan for Social Care that complements and augments the NHS People Plan. We need to develop a clear career progression, better recognise and value staff, invest in their training and support, and introduce professionalisation and registration where this is appropriate. This will improve our ability to recruit and retain high quality, skilled social care staff with the right values and our ability to grow innovative models of support, as well as to develop and recruit a workforce that reflects and understand the needs of communities being served.

5.5 The pandemic has shone a spotlight on the social care workforce vis-à-vis the NHS workforce. Both are comparable in terms of numbers but the former is much less supported, rewarded and recognised. This needs to change.

DHSC's effectiveness in overseeing the market & holding providers to account;

6. The NAO report finds that:

'*Current accountability and oversight arrangements are ineffective for overseeing a disaggregated market. While the Department is responsible for securing funding for care, the Ministry distributes most grant funding to local authorities based partially on an out-of-date adult social care funding formula. In recent years ad-hoc funding increases have been required. Despite its high-level objectives for care, the Department lacks visibility of the effectiveness of local authority commissioning'.*

Also important, it notes that;

'*In February 2021, the Department outlined proposals which include increasing its oversight of local authority delivery of social care and improving the data it has to assess capacity and risk in the system'* and that *'In response to COVID-19, the Department has increased the data it obtains on care providers and it intends to legislate for new powers to collect further data'*[13]*.*

As the NAO report highlights, DHSC's current oversight arrangements are ineffective; this has been highlighted by the pandemic and the lack of data that DHSC had. We will come back to the question of data in the next section.

6.1 The NCF would add to the NAO's points about the role of the DHSC here. In our view, it is critical that the DHSC also hold local authorities to account for way in which they

[13] Ibid, pp. 8-9.

discharge their social care duties and responsibilities and hold local systems being charged with responsibility for delivering health and care to account.

6.2 The recent Health and Care white paper offers an ICS model intended to present opportunities to join up health and care to bring it closer to the communities and people that need it and improve collaboration between all the partners and providers involved in making that happen.[14] However, at present, the focus of activity, the governance proposals, the ICS model and the ambition in the white paper are far too health focussed and miss two key elements of the wider local health and care system – those who use it or will need to use it and those organisations that design, create and provide social care.

6.3 In the NCF's response to the white paper (will be published on Health and Social Care Select Committee website in due course), we suggest a standard national framework and model for the membership of ICSs that mandates and financially supports the involvement of the voluntary, not-for-profit adult social care sector and the people they serve which gives them a clear role in decision-making, governance and accountability. Without this safeguard, there will be a patchwork of local arrangements that will not support the ambition of the ICSs to meet the needs of their population properly in terms of care as well as health and it will be increasingly difficult for care providers to deliver the range and quality of services needed in isolation from being properly embedded in and understanding of context of the wider local system.

Better oversight of the market - CQC Duty to assess LAs and additional powers to Secretary of State

6.4 The proposal to introduce a new duty for CQC to assess LA's delivery of their adult social care duties in the Health and Care white paper is very welcome and long overdue and we look forward to more detail on what exactly this will involve. The National Care Forum has long called for such oversight. Better assurance and oversight of the way LAs commission and fund social care is incredibly important, especially in the context of the CQC draft strategy, which proposes a greater focus of regulation to improve people's care by looking at how well health and care systems are working together and how they're acting to reduce inequalities. It is, of course, important that the CQC and DHSC recognise and understand the extent to which providers actually have the necessary powers to effect change in this regard. We note the proposal in the Health and Care white paper that the Secretary of State takes the power to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties.

6.5 We also note the proposals to extend the Secretary of State's existing power to directly pay not-for-profit health and care providers to all care providers. This is presumably

[14] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

informed by the challenges during the pandemic of directing funding to the frontline of social care and the limitations experienced by having to channel money via LAs. We welcome the proposals but note that, of course, that the Health and Care white paper is silent on the wider challenge, which is the wider reform of social care and resolving the systemic problems that exist in current funding and commissioning of social care.

The DHSC's understanding of future demand, costs and alternative delivery models

7. The NAO report notes that the DHSC has done some modelling on future demand: '*The Department projects that if current patterns of care continue, around 29% more adults aged 18 to 64 and 57% more adults aged 65 and over will require care in 2038 compared with 2018. Between 2018 and 2038, the total costs of care are projected to rise by 90% for adults aged 18 to 64, from £9.6 billion to £18.1 billion, and 106% for adults aged 65 and over from £18.3 billion to £37.7 billion'*[15].

The report also notes that there are significant data gaps in terms of the adult social care sector's overall performance, costs, unmet need and information about self-funders.

Maximising the power of digital and data in social care - the Data Strategy for Health and Care must be co-created with social care providers as well as users of care and support services

7.1 As the NAO report highlights, the first wave of the pandemic highlighted just how little data central government and local government held about adult social care, and in particular those who self-fund their care. In response, DHSC adopted the Capacity Tracker and various local authorities created their own equivalents, all seeking to collect data from, care homes at first, and now the wider adult social care sector, in order to inform the response to COVID-19.

7.2 The Health and Care white paper seeks to build on the Capacity Tracker by consolidating and centralising data collection from adult social care providers for DHSC and other parts of the health and social care system.[16] The proposals in the white paper certainly identify the problems in term of consistent and accessible data for social care, but we must learn from the issues with the Capacity Tracker and find a better long-term solution.

7.3 The Capacity Tracker represents an amalgamation of emergency pandemic data collection, built on short-term requests for particular pieces of data to answer urgent pandemic related policy questions. It is not the basis from which to build a meaningful data strategy for the care sector. It is also incredibly burdensome for care providers to

[15] Ibid, p. 10.
[16] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

complete. Providers described a range of challenges associated with data sharing during the pandemic, such as[17]:

- The 'relentlessness' of responding to daily requests which could have a significant effect on their working day – including duplication by different commissioners who do not share information with each other.
- Interpreting frequently changing guidance and communicating these changes to staff, service users and their families
- Dealing with new and changing data demands
- Receiving frequent and unscheduled phone calls requesting data.
- Little perceived benefit to sharing data – it often did not result in any substantial additional support

These pressures and challenges have been consistently echoed by our members and the National Care Forum (representing ourselves and the Care Provider Alliance) has played a pivotal role in the ongoing liaison between the DHSC, the NHS and the care provider sector to voice these issues. A fundamental rethink of the aim and purpose of the data needed is required to build a coherent data strategy.

7.4 The data strategy must look beyond a centralised data collection for DHSC. Care must also be taken to recognise the different 'data philosophies' in social care and the NHS. The sorts of data desired by NHS commissioners and clinicians will be very different to that desired by LA commissioners and social care providers – we need to ensure that the correct data is captured. It must also balance data burden with data benefit and a clear indication of how the effort needed for data flows are resourced.

7.5 There is important research work going on in the DACHA study[18] which aims to create a minimum data set for care homes. It aims;

a) to establish what data need to be in place to support research, service development and uptake of innovation in care homes and,
b) to synthesise existing evidence and data sources with care home generated resident data to deliver a minimum data set (MDS) that is usable and authoritative for different user groups (residents, relatives, business, practitioners, academics, regulators and commissioners).

Both the government and the Committee need to understand that this important work is underway and the data strategy needs to be informed by it.

[17] Skills for Care commissioned research 'How social care providers have dealt with data demands during the COVID-19 pandemic'

[18] Developing research resources and minimum data set for Care Homes' Adoption and use (DACHA). It is a collaboration between the Universities of Hertfordshire, Cambridge, East Anglia, Newcastle, Leeds, Nottingham, Kent, Exeter, Glasgow; The Health Foundation; and the National Care Forum; led by Professor Claire Goodman, University of Hertfordshire (Chief Investigator). https://arc-eoe.nihr.ac.uk/research-implementation/research-themes/ageing-and-multi-morbidity/amm01-developing-resources-and

7.6 We need more robust data collection and analysis which involves both social care providers and those accessing care. Improved data collection requires resource and a focus on the right data at the right time with a rounded analysis. Social care has been locked out of that during the pandemic with the Capacity Tracker data being unavailable to the providers that supplied it. This is a real opportunity to build a shared view of what data matters and for us all to use it to improve what we do and create procurement and commissioning practices which are more informed. We need an approach which engages the whole sector in a specific locality, including those using care services now (both self-funders and publicly funded) and those who may need to use it in the future and their families.

7.7 The forthcoming Data Strategy for Health and Care must be co-created with social care providers as well as users of care and support services.

Creating an innovation and technological development infrastructure fund

7.8 COVID-19 has highlighted the essential role that **technology** can play in social care and the significant impact it can make in improving the quality and timeliness of care. We have seen a rapid acceleration of the use of digital technology, both to support the move to more virtual health care support via virtual consultations, virtual home visits/ ward rounds and the expansion of the use of NHSmail, as well as to improve connectivity with family and friends via digital tools.

7.9 The NCF recently ran an innovative digital project called The Hubble Project, aimed at helping boost the sector's digital maturity by supporting social care providers to showcase the digital technology they were already using to the rest of the sector, offering virtual visits to their 'innovation hubs' via a series of webinars to learn how they introduced, used and evaluated digital technology to improve care.

7.10 The project has been very successful, providing valuable peer learning across the sector, offering real insight into how the digital tech in place in each hub improves the care provided – and how data from technology can help to provide truly person centred care, tailored to each individual, to improve overall wellbeing, take early preventative action, spot trends and patterns and improve management decisions. Other benefits of the technology were also explored, from the benefits of going paperless to the power of data and intelligence in service audits and inspections.

7.11 Our view is that the government must capitalise particularly on the potential of digital technology with the creation of an infrastructure fund which would enable the sector to seize the opportunity to invest in the rapid adoption of proven technologies, which can enhance outcomes, such as machine learning, assistive technology and predictive analytics. **We need support to stimulate further development, complemented by a meaningful investment in the architecture to support the development of a digitally enabled social care sector.** These combined **funds** would support councils and support

providers to make best use of technology. It would also support bringing evidence based (but currently marginalised) positive models of care and support into more mainstream use. This fund could also be used to develop and rapidly test solutions to particularly challenging care problems.

8. Social Care reform

The NAO report is very clear about the urgent need for the DHSC, to *'as a priority, set out a cross-government, long-term, funded vision for care'*[19].

8.1 Everyone agrees that adult social care needs reform. Even before the COVID-19 pandemic, there was a consensus that our current social care system was in urgent need of both immediate funding and longer-term funding and reform. Those who use the system know this, as do those working in the system, charities, others providing services as well as think tanks, experts of all descriptions and politicians.

8.2 Reform will require an ambitious long-term vision. We do not need another inquiry or commission. These have already been carried out and we have their proposals[20] – it is time for political bravery and moral courage from across the political spectrum. It is time to act.

As the National Care Forum, working closely with our diverse membership, building on their unique perspective and experience as not-for-profit providers embedded in their local communities, and in discussion with a wider set of stakeholders, we have developed a guiding set of principles to underpin the reform of social care:

1. It must enable the provision of a choice of good quality, responsive, person centred care for those who need it (both working age and older people)
2. It must be co-produced with the voices of the people who use care now and who will use it in the future
3. It must enable a focus on prevention and address the very serious issue that underfunding has created, forcing the restriction of eligibility to those with the most substantial care needs only
4. It must enable the full principles of the Care Act 2014 to achieve people's independence and wellbeing
5. It must provide fairness and certainty for people who need to use care
6. It must provide proper reward and recognition for staff who work in social care
7. It must be intergenerationally fair
8. It must embody a human rights approach for those receiving care and support and the workforce

[19] https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf p.12.
[20] Some of the more recent examples include: The Dilnot Commission Report 2011, The Barker Commission 2014, LGA Green Paper on Adult Social Care 2018, HoL – Social care funding: time to end a national scandal July 2019, & H&SC – Social Care: Funding and Workforce report 2020

NCF ask: Invest in Adult Social Care to ensure it has sustainable funding and contributes to economic recovery

8.3 The social care system immediately needs additional funding of at least £7bn per year in England to simply stand still and deal with demographic changes, the fallout of the pandemic, uplift staff pay with the National Minimum wage and to protect those facing catastrophic social care costs.[21] Longer-term, significantly more per year is required to create a social care system that is sustainable, accessible to everyone that needs it, provides the best care possible and removes the perverse 'cross-subsidy' for private funders created by the underfunding of publicly funded care packages. We need a system that enables people to live to their full potential and contribute fully to their communities and wider society.

8.4 So far, the government has fallen woefully short in addressing funding pressures. The government increased funding to social care by £1bn per annum (split between adult and children's social care) following the December 2019 General Election[22]. An additional £1bn was promised as part of the Spending Review in November 2020 but only £300m of this was being funded by central government and was again split between adult and children's social care. The remaining £700m is to be raised by Local Authorities increasing the social care precept.[23]

8.5 This a fundamentally ineffective and unfair way to fund social care because poorer areas have more people eligible for publicly funded care but less capacity to raise money for it. Further emergency injections of cash into the system through the various iterations of the Infection Control Fund as well as the Rapid Testing Fund and the Workforce Capacity Fund while a welcome sticking plaster, do not offer a sustainable solution to the funding pressures. We were disappointed to see that adult social care was completely absent from this year's Budget. Urgent action is required to address this.

8.6 Investment in Adult Social Care will bring many benefits for society beyond improved care for those who need it. In 2018, **Skills For Care** found that the economic benefit of the care sector in England alone was £38.5bn. Social care is very much a local enterprise, providing local employment in local areas, bringing the economic benefit of local wages spent in local shops and businesses, supporting local supply chains and paying local taxes. It is time for government policy to recognise social care as a vital contributor to the economy.

NCF ask: **Stimulating the growth of the not-for-profit sector**

8.7 The NAO report states that **'***Independent providers run most care homes; based on market value, 76% of care homes for older adults and adults with dementia are for-*

[21] As pointed out by H&SC – Social Care: Funding and Workforce report 2020
[22] The Conservative Party Manifesto December 2019 – Pg 12.
[23] Spending Review November 2020

profit. Of the remaining 24%, 14% are not-for-profit and 10% are run by a local authority or the NHS.[24]'

8.8 We would like to propose to the committee the importance of stimulating the growth of the not-for-profit care sector. Public research done by the NCF during the summer and autumn of 2020 showed that the public has a clear preference for not-for-profit care provision. The public expressed greater confidence in relation to the quality of care and the trust in the organisation delivering it.

8.9 In addition to this, there have been a number of reports that identify some of the challenges of social care sitting with profit making commercial providers. The research carried out by IPPR in 2019 showed that more than eight out of 10 care home beds are provided by profit-driven companies, including more than 50,000 by large operators owned by private equity firms[25].

8.10 Social care delivers public good, much of it funded by the public purse. Primary legislation such as the Social Value Act also exemplifies the importance of using public money to invest in services that support wider community ambitions. Not-for-profit care provision ensures that all of the funding from either government or citizens is directed towards the delivery of care now and in the future. There is a real opportunity for Government policy around funding and reform to recognise the enormous potential for not-for-profit care in delivering greater returns to the communities that they serve and to look to incentivise this model of provision through both the reform and funding agenda.

The impact of COVID on the market and the sector's financial sustainability

The NAO report notes that *'COVID-19 could have short- to medium-term consequences for the market's financial sustainability'*[26]. Undoubtedly, the direct financial support from the Government via the Infection Control Fund and the Rapid Testing Fund has helped but cost pressures remain very significant.

9. The picture of the economic impact of Coronavirus on the not-for-profit care sector

9.1 At the National Care Forum, as part of our work to feed into the Comprehensive Spending Review in the autumn, we asked members who provide care home services for financial information on costs and occupancy/ demand for 2019/20 – 2020/21 to assess the monetary impact of Covid-19. **The findings showed that, across the board, costs are up significantly, resident numbers are down, overall surpluses will be down by 71%**

[24] https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf p. 26
[25] https://www.ippr.org/files/2019-09/who-cares-financialisation-in-social-care-2-.pdf
[26] https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf p. 7

compared 31/3/20, with many slipping into deficit. Grants have assuaged some of the damage, but there is a need for longer-term funding to fill the gap that has emerged because of COVID-19.

9.2 Our members, who are all not-for-profit providers of care and support, are experiencing a damaging combination of large rises in their costs and significantly reduced income due to occupancy levels: equipment costs have risen by 15% and supply costs have risen by 55% (this includes PPE) while occupancy levels are forecast to fall by 9.2% this year (an 8.8% fall in LA funded residents and a 10% fall in self-funders). Waiting lists also give a good indication of demand and the forecast for 2020/21 is that these will be down by 50% compared to 2019/20. We also looked at the impact of increases in costs by calculating an average operating cost per care home place, and while this is, of course, highly variable between organisations, we found it will rise on average by £5k per place.

9.3 To add a little more detail to the enormous increase in COVID specific cost pressures, the list of these includes:

- unfunded PPE (the free PPE did not arrive until October 2020 and it does not cover all COVID related needs)
- enhancements paid to staff to pick up extra shifts
- cohorting staff into bubbles and the restricted movement of staff
- sick pay for multiple periods of isolation as well as for illness
- costs to support individuals travelling to get their vaccinations
- the increased costs of agency staff and block booking arrangements
- the creation of dedicated visitor rooms
- the other additional costs of visiting, creating waiting areas and testing areas, visitor testing and cleaning between visits
- the costs of enhanced IPC measures since the start of the pandemic
- the costs of significant data gathering required by the daily Capacity Tracker and other monitoring and reporting requirements
- eye watering hikes in the cost of insurance for social care providers with access to public liability cover disappearing entirely for some

9.4 While some of these costs will be met by the Infection Control Fund, by no means will all of them be covered in full and care providers will have to meet these significant costs. Alongside these significant increases in costs, care providers are facing a longer term challenge of lower occupancy – forecasts from sector experts Carterwood indicate that overall care home occupancy levels will not return to pre-pandemic levels until November 2021 in the best case scenario and that it actually may take until summer of 2022 to do so[27].

[27] https://www.carterwood.co.uk/light-at-the-end-of-the-tunnel-occupancy-could-return-to-pre-pandemic-levels-by-nov-2021/

9.5 Thinking more widely than care homes, community based services, such as support services for older people with dementia and people of working age with learning disabilities and autism, have experienced other, equally difficult challenges. Few were able to run as normal, meaning that fewer vulnerable people and their families are getting the support they need. Local authority funding for their services has reduced and income from people who pay for their own community services is also down.

9.6 Prior to the COVID-19 crisis there was an estimated shortfall of £8bn per year in terms of funding for the sector. The additional costs of COVID-19 have added an estimated £6bn to that bill, just for 6 months from April 2020 – September 2020.

9.7 In its 2020 Budget Survey[28], ADASS reported that the pandemic had made care markets 'extremely fragile' and susceptible to market failure. There needs to be a fundamental rethink.

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[28] https://www.adass.org.uk/adass-budget-survey-2020