Homecare
Association

Lifting the veil: Removing the invisibility of adult social care

Homecare Association submission to the House of Lords Adult Social Care Committee's call for evidence

Submitted online, 27 May 2022

Who are we

A. The Homecare Association is a member-led professional association, with over 2,300 homecare provider members across the UK. Our members encompass the diversity of providers in the market: from small to large; predominantly state-funded to predominantly private-pay funded; generalist to specialist; and from start-ups to mature businesses. Our purpose is to enable a strong, sustainable, innovative and person-led homecare sector to grow, representing and supporting members so that we can all live well at home and flourish in our communities. As such, our response to this call to evidence will focus on the social care sector, with a specific interest in care delivered in people's own homes.

Executive Summary

B. It can often feel that the adult social care sector is 'hidden in plain sight' as the day-to-day challenges of those involved in social care are poorly understood and narratives about the sector experiencing crisis become 'normalised'.

C. Policy announcements can feel disconnected from the realities experienced by providers. Escalating unmet need, staff shortages and funding deficits remain largely unaddressed by the reform proposals.

D. The value of the sector and what it means to those who draw on, or are involved in, social care needs to be made visible and understood.

E. It is important for the public to know what to expect when they need care and support. While about two thirds of people are aware of homecare services in their area (YouGov, 2021), many are not clear on how this is paid for or accessed. It is often difficult for individuals to plan for their own needs because they do not know what the future holds for them. This makes it more important that there is good public awareness and discussion around the range and quality of services that are provided.

F. It is also important for the realities of the sector to be visible to policy makers so that they can appreciate and address the challenges the sector is facing.

G. Key actions that could be taken to address these issues include:

i. More **national public dialogue** about care and better national representation of the people who draw on care services and their families, as well as the wider sector. Relying too much on local authorities to undertake communications work risks leading to varied results across the country and may lead to lower national media interest than might otherwise be achieved. This will require resource to understand current public views and support engagement.

ii. Public services should **pay viable fee rates** to care providers when they commission services. The funding set aside for the Fair Cost of Care reform is insufficient.

iii. Provide immediate support to the sector: **grants for homecare workers to cover additional fuel costs must be made available.**

iv. There is an urgent need for the Government to develop a **credible workforce plan for social care**; this must be combined with funding to support adequate pay, terms and conditions and career progression.

v. Careworkers should be permanently added to the **shortage occupation list and complexity and cost of recruiting overseas workers reduced.**

vi. We support the Migration Advisory Committee's recommendation in their 2022 review of adult social care immigration that ONS and other **official data should separate the social care and health care sectors**.

vii. Those involved in the sector could be consulted on the **further development of the national 'CARE' brand.**

viii. **Funding for academics** researching social care issues should be sustained and increased.

ix. **NHS training should include more about social care**, including cross-sector placements.

H. The remainder of our response is structured around the Committee's specified questions.

The invisibility of adult social care and its consequences

1. One of the fundamental challenges facing adult social care is that it is 'invisible'. Do you agree? What do you think explains this?

1.1 Most people know someone who has received care and support and someone who has worked in a social care service. Yet the experiences of the sector and issues facing the sector have poor visibility and are not well understood. Care is 'hidden in plain sight'. Of course, the Committee will be aware of a range of social factors which have influenced the 'invisibility' of care, and which will be discussed in more detail by others:

i. Care and support has a gendered history and has been culturally viewed as a family or 'private' issue and not a public issue.

ii. There is a lack of understanding about how care and support is paid for and provided amongst the public..

iii. The history of care in people's own homes being understood as 'home helps' who undertook routine domestic tasks may obscure the range and complexity of support provided to people in the community today.

iv. Disabled and older people, using care services, are more likely to experience prejudice and discrimination and to find that their voices are systematically undervalued by our society. Similarly, those working in the care sector are often women, who are often on low-pay and their voices are not given the same political weight as workers in historically male-dominated professions.

1.2 We would like to draw attention to some additional points that we believe are critical:

i. After years of underfunding, and escalating unmet need, narratives talking about **crisis in the social care sector appear to have been normalised.** This means that when we see ADASS saying (in May 2022) that there are half a million people waiting for assessment, care, direct payments or review there is relatively little reaction. In fact the stories behind these figures in terms of the impact on both individual lives, the workforce and health and care systems is something that should be receiving urgent attention at the highest level.

ii. **Policy disconnect** – some of our members have told us that they feel that Government policy is disconnected from their day to day reality and what demographic projections tell us about what the future holds. Many care providers are dealing with multiple phonecalls a week where they have to speak to people who have urgent needs and decline to provide support due to

capacity issues. This often has an emotional impact on staff. To then see policy rhetoric about choice, control, outstanding and accessible care, when capacity issues seem unacknowledged or addressed can feel jarring. Similarly, careworkers who have experienced the rollercoaster of taking the personal risks of delivering care early in the pandemic, through ‘clap for our carers’ and then experienced the loss of colleagues through Vaccination as a Condition of Deployment, and the loss of paid isolation leave with the ending of the Infection Control Fund will not now necessarily feel valued or like their perspective is ‘seen’. Their reality does not feel recognised within recent policy decisions.

iii. There are **degrees of invisibility *within* social care**. Throughout the pandemic we have repeatedly found (in engagement with the Government) that forms of care delivered outside of care homes appear to have been treated as an after-thought, with the bulk of media and political attention being paid to care homes (this can be seen in policy actions also: care homes had much earlier access to COVID-19 testing and PPE than other parts of the social care sector. While risk from COVID-19 is higher in congregate settings we believe the attention given to the rest of the sector has not been proportionate. We have also found that we repeatedly need to request that officials take the wider social care sector into account; without frequent comments from stakeholders the official narrative in many instances would likely barely acknowledge the wider range of ways of supporting individuals in the community; even though the *People at the Heart of Care* white paper focuses on supporting people at home. Another example of this would be the degree of attention given to care homes compared to the rest of the sector in recent House of Commons Library briefings. Furthermore, NHSX plans for digitisation of the care sector focus mainly on care homes.

iv. **Strategic oversight of care is fragmented** – although the NHS is large and complex and involves a lot of distinct organisations, the overall concept and brand is recognised and understood. There are 152 local authorities in England commissioning social care, as well as over 100 CCGs. Some people also pay for their own care. The ‘CARE’ brand that was launched in the pandemic is not yet widely recognised or understood.

v. **Political leadership** – some aspects of social care can be seen as a problem for local authorities; meanwhile social care is overshadowed in the Department of Health & Social Care by NHS issues. Central government appears ambivalent towards the care sector, frequently seeking to deflect responsibility to providers for issues such as pay, terms and conditions of employment, though a majority of care is dependent on state funding. Even though there is a Minister for Care and Mental Health, there remains a risk that the sector is side-lined in the

Westminster Government and responsibility for issues is not fully owned by central government due to the relationship with local government and the fact that many issues in the care sector require cross-government communication and cooperation.

vi. Carework has not been made **economically visible**. While the pandemic made clear that careworkers are key workers, their economic value is often not recognised. The economic benefits of care (including for example, releasing unpaid carers so that they are able to work and enabling shorter hospital stays) are often not fully considered. An analysis commissioned by Skills for Care indicated that the economic value of the care sector is at least £50 billion. The understanding of the emotional, relational, communication and other skills involved in carework is also low.

2. What are the key changes that need to be made to reduce the invisibility of adult social care?

2.1 The following changes could be considered:

i. Professionalisation of care work by developing an adequately funded knowledge and skills framework, leading to recognised career pathways, fair reward and ultimately a professional register. A hundred years ago, a professional register was created for nursing amidst substantial opposition. Ultimately, though, this has raised the profile and perceived value of nursing in society.

ii. Greater collaborative working in multi-disciplinary teams with the NHS. In some places, e.g., Devon, care workers have been allowed to add the NHS logo alongside the care logo on their uniforms, which has made a substantial difference to the respect with which they are treated by other professionals and by people drawing on services.

iii. Those involved in the sector could be consulted on the further development of the national ‘CARE’ brand.

iv. There needs to be more national public dialogue about care and better national representation of the people that are supported by care services, and all involved in the sector, in the media. This needs to be well informed. In countries such as Japan and Germany there were well-organised and strategic discussions nationally about the vision for health and care services, emphasising the benefits to everyone from greater investment.

v. It is possible that we could learn from the public opinion and comms work that other parts of the health and social care sector use (such as public health campaigns) to inform a sector wide communication strategy addressing key knowledge gaps. This is likely to require funding and other kinds of support that the

sector does not have readily available. Relying solely on local authorities to undertake communications work will lead to varied results across the country and may lead to lower national media interest than might otherwise be achieved.

vi. Currently many national statistics group health and social care together as one sector. Statistics may then be analysed on the assumption that they are about the NHS. We support the Migration Advisory Committee's recommendation in their 2022 review of adult social care immigration that ONS and other official data should separate the social care and health care sectors. When social care is considered separately, no distinction is made between for example care homes and other care settings, such as homecare. More granular analysis is required.

vii. Increased funding for academics researching social care issues so that the available evidence about social care becomes more accessible to policymakers and the work of the sector, problems and potential solutions to those become better understood.

viii. Production of quality data on social care would help in many ways – importantly to enable personalisation of care and a focus on outcomes, as well as driving improvement in quality and safety, but also to provide data to assist in policy making and research. This needs to be done in a way which minimises the burden of data collection. Ensuring adequate investment in digital transformation of homecare is key to efficient and effective creation of relevant data.

ix. See also, our response to question 7 on what NHS and other public sector organisations could do.

3. How does this invisibility reflect the experience of social care for people who draw on care and support and their carers, and how is this experience different depending on the age range and particular circumstances of those who draw on care and support and their carers?

3.1 There are several well-documented issues, which the Committee will be aware of. These include a lack of understanding amongst the public about social care services, which can make it harder for people who develop care needs to know what options they have, and how to access or pay for care.

3.2 The issues with invisibility affect the political agenda and therefore, also, spending. Over the ten years 2009-2019 Institute for Government analysis shows that real terms public spending on adult social care fell by 2% whereas spending on hospitals increased by 19% over the same time period. Funds raised by the Health and Social Care Levy have largely gone to the NHS (it was initially estimated that this would raise £36 billion, £30.3 billion of which will go to England over three years, with £5.4 billion over three years to social care and the rest to the NHS

– this represents less than a fifth of funds raised going to social care, despite well documented needs for additional funding).

3.3 Lack of funding can have an impact on the working conditions in the sector. Though reputation and visibility of the sector are also factors that affect staffing. In turn staff shortages limit the supply of services and impacts people's experience of waiting for, and receiving support from care services. The vacancy rate in homecare has now risen to 13.5% and the number of hours of homecare that commissioners have found that it has not been possible to deliver (largely due to staff shortages) over the last year has risen 671%.

4. How would you define the purpose of adult social care? How does the invisibility of adult social care get in the way of achieving this purpose?

4.1 At the Homecare Association we believe in a society where we are all able to live well at home and flourish within our communities.

4.2 In 2021, we undertook a YouGov survey of the public. One of our questions asked which type of care service they would prefer (homecare and housing with care were the most popular options, with 40% of respondents selecting each). However, regardless of their preference, the most popular reason for their choice was that they believed that it would enable them to "live the way I want and be myself with my needs and preferences being respected and met (e.g. the food I eat, my spiritual needs, my sexuality, the people I see, the language I speak etc.)". We think this is a key aspect of what good care looks and feels like.

4.3 While there are multiple factors affecting how easy it is to achieve this, we are particularly concerned at the moment that the invisibility of adult social care is contributing to a lack of funding and a shortage of staff, which is significantly limiting the availability of care.

5. To what extent does the definition of the purpose of adult social care differ for younger and for older adults? How can future reform of the adult social care system best address these differences?

5.1 We do not think that the purpose of adult social care is fundamentally different for younger and older adults.

5.2 All people with care and support needs should be supported to live well at home, regardless of their age.

5.3 In line with the UN Principles for Older Persons and the UN Convention on the Rights of Persons with Disabilities, people of all ages should be able to access support to participate meaningfully in their communities (whether that is through work or education or through volunteering or attending social, religious or other events) and live with dignity. People of all ages should be supported to maintain the significant relationships in their lives.

5.4 While some younger adults with support needs will be working or have care responsibilities for children, there may sometimes be older adults with support needs who are also wanting to work or care for children or grandchildren. The support provided by social care should be personalised to the individual and not be limited by assumptions about what people of that age do.

5.5 While sometimes a persons' needs will be shaped by a particular condition, like dementia, which is more prevalent at certain ages; it is the condition and not the age that shapes a person's needs. Sometimes younger people develop conditions like dementia also. Good dementia care should also be personalised.

5.6 We are concerned that increased demand for social care and staff shortages will impact access to care for disabled people, including those under the age of 65. We know that other issues, such as issues with local authorities' charges have had a significant impact on adults in this age group.

5.7 We are also concerned that the way that care at home has been, and still is, commissioned (by time and task) appears to lead to a focus on washing, dressing, eating and personal care to the exclusion of other needs. This is exacerbated by underfunding. Our previous campaigns against commissioners' use of 15 minute visits (not only in 2013, but also last year in Northern Ireland), also suggest a lack of adequate consideration for the dignity of people drawing on services, and we believe these issues – time and task commissioning and 15 minute visits – are more prevalent in the commissioning of care for older people.

5.8 However, these are differences in the prevalence of certain issues and not differences in the fundamental purpose of social care provision. Care and support should be shaped by individuals' needs and preferences more than their age.

6. What are the key challenges that people who draw on care and support and carers will face in the future, which are not factored into current assumptions related to the social care system, for example the fact that some families will age without children to care for them? How are these challenges different for younger and for older adults who draw on care? What should be done now to address them?

6.1 There are obvious concerns about demographic trends that the Committee will be aware of that indicate an increase in demand.

6.2 Increased need for care is likely to lead to increased pressure on family members and friends to take on unpaid care roles, so we could see significantly more unpaid carers in future. This would mirror what we saw during the pandemic when there were increased levels of need and demand for care with Carers UK estimating that an additional 4.5

million people in the UK had become carers as a result of the COVID-19 pandemic by June 2020. Increasing complexity of care needs with lack of availability in paid-for care services may also make the care roles that people are undertaking more demanding. At the same time in coming years we may see changes in patterns of unpaid caring as family structures are becoming more complex, families are more dispersed, less people are having children and there are increased economic pressures to work.

6.3 We know that people that take on unpaid caring roles that are too demanding can suffer detriments to their immediate and long term health, wellbeing and financial situation. In 2021 Carers UK reported that 1 in 5 working carers said that without affordable and accessible care services they may have to reduce their hours or give up work altogether. People reducing hours or leaving their paid work to undertake unpaid caring roles can have wider economic impacts, including loss of skilled workers in the immediate; with the potential for increased demand for health services and lack of pension provision in the longer term.

6.4 We are also concerned that there will be significant difficulties with recruiting and retaining the care workforce needed to meet demand for paid-for (whether by the public or individual) services.

6.5 It has previously been projected that the social care sector will need 480,000 additional job roles filled by 2035 (Skills for Care). More than 1 in 8 homecare roles are already vacant and our members are telling us that recruitment and retention has never been more difficult (Homecare association surveys on staffing: July 2021; August 2021; November 2021; January 2022). Demand for careworkers will be rising globally, meaning that migration alone may not be able to resolve this issue (though the addition of careworkers to the Shortage Occupation List is welcome, and we suggest this is made permanent). We, also call on the Government to make it as easy as possible to recruit; with many providers struggling financially, we believe that the removal of the Immigration Skills Charge for all careworker visas (as recommended by the Migration Advisory Committee) would make a difference.

6.6 There is an urgent need for the Government to develop a **credible workforce plan for social care** to address these risks as far as is possible; this must be combined with funding to support adequate pay, terms and conditions and career progression.

6.7 Thought also needs to be given about how to support people if we are not able to recruit the workforce that we desire in future according to our current health and social care model. One key factor here is adopting a preventative approach and recognising the potential of social care services to assist with the preventative agenda so that people can be supported to maintain their health and wellbeing without avoidable escalations in need.

6.8 Care services may also be able to reduce demand on health services and better support people with multiple health conditions if careworkers are trained to undertake some of the health-care tasks that community nursing teams currently provide (though they would need to be trained and compensated accordingly). In some cases, this could reduce the number of people that an individual receiving care and support needs to see in order to receive the care that they need.

6.9 We believe that technological solutions (including robotics and AI) have the potential to enable people as part of this picture, in such a way that they need less support and also to assist careworkers with their jobs. This is not to say that the human elements of caring can be replaced. Tech solutions could range from simple medication reminders and communication aides, through to more complex bionic/exoskeleton support that can assist people with mobility impairments to be more mobile. There is also room for development in terms of what equipment is available to help to safely move people from bed to a wheelchair, for example. All of this technology would need research investment, but this could pay dividends if successful, particularly if the supply of careworkers and unpaid carers is limited.

6.10 Use of digital technology to track health metrics, such as use of blood pressure monitors at home, could also be useful. We know of members who have successfully used monitoring to detect UTIs early, for example, with improved outcomes for the people being supported and resulting in lower demand on health services. However, some of our members who have used such technology have also found that health systems do not necessarily have the capacity to provide support when monitoring systems detect abnormal results. A joined up response across health and care is required.

6.11 Care services will need to remain mobile whilst relying less on carbon based fuel. Rising fuel costs are currently a significant issue for the homecare sector. We have suggested making electric fleet vehicles available to care staff. There may be other climate related needs, in relation to care services needing to deal with caring for people during higher temperatures, supply shortages, further pandemics or extreme weather, for example. The Government and the sector needs to collectively learn from emerging events to prepare for the future. Our experience during the pandemic has raised our concerns about the quality of Government contingency planning and the degree to which it take social care into account.

6.12 Other factors, such as the impact of COVID-19 on longer-term health and care needs, an increase in obesity and dementia will shape the demand for care services. These need to be taken into account in equipment design, training for staff and strategic planning at a national level.

6.13 Sufficient provision of age-appropriate housing, including development of inter-generational communities, is essential. The UK has fallen far behind countries such as the USA, Australia and New Zealand in suitable housing provision and this needs urgent attention.

6.14 Rising levels of life-long renters may also shape how easy it is to adapt housing and meet people's care needs. This should feature as part of the Government's consideration of housing outlined in *People at the Heart of Care*.

6.15 Aside from all of these points, maintaining and growing existing provision and making that more resilient and adaptable seems vital. However, what we are hearing from members is that it does not feel like the sector has recovered from the pandemic yet. While society returns to a 'new normal' care staff are exhausted, resources are stretched and COVID-19 (with associated guidance) is still with us. The sector needs immediate support, such as the reinstating of the Infection Control and Testing Fund and financial assistance with fuel costs.

7. How can other public services (such as the NHS) play their part in tackling the invisibility of adult social care?

7.1 Public services, including the NHS, can make social care more visible in the following ways:

i. **Paying viable fee rates** to care providers when the NHS commissions services. We annually calculate a minimum price for care based on what we believe is necessary to meet statutory requirements on providers, pay all contact time, travel time etc. and cover overhead costs such as the managers time, telecoms, office costs and so on. In fact, the amount needed may be higher than this if local labour market means recruitment at the minimum wage is not feasible (this is currently £23.20 per hour). In 2021 we requested data from public sector organisations under Freedom of Information legislation and found that only 13% of public organisations that provided figures were paying an average price that was at, or above, our minimum rate (which should be an absolute minimum, based on the statutory minimum wage). In some cases, NHS commissioners (who commission about a quarter of homecare services, and often for more complex care) paid less than local authorities in the same area.

ii. **Pooling budgets for joint commissioning with local authorities of homecare.** The additional funding available has the potential to facilitate new models of care and new ways of working in technology-enabled multi-disciplinary teams across integrated care systems. It would also create opportunities for workforce development and building of workforce capacity. As mentioned earlier, allowing care workers to wear the NHS logo alongside the

Care Badge has made a substantial positive difference to esteem in some places.

iii. **Speaking publicly about how social care is important** to keep the NHS running now and how it will be important in the future as health and social care services need to rise to the challenge of an ageing population and increasing need levels. Matthew Taylor, NHS Confederation, has done this, we need more NHS leaders to do so.

iv. **Treating the care sector as an equal partner**. Care providers should be engaged in strategic discussions; including through Integrated Care Systems. There is a tendency to assume that the social care sector can be represented by those involved in statutory roles (such as local authorities) in that area; however, the vast majority of care is delivered by providers in the independent sector who encounter day to day issues. This can make it difficult to have genuine discussions about the operational issues around integrated care. (This issue is covered in a report we recently published with the Good Governance Institute and Care England).

v. Not all NHS staff are aware of how social care systems work and we hear reports of homecare staff being looked down on by NHS staff. However, even if some social care staff have lower levels of training than NHS nurses, for example, they often spend more time with the people that they support than anyone else. Their voice and expertise needs to be recognised by health professionals. In other cases we encounter situations where NHS colleagues have made decisions with poor outcomes due to a lack of understanding about how social care works. **NHS training should include more about social care**, or possibly even cross-sector placements. Nurse training, for example, should include rotations in care services.

vi. **NHS colleagues could offer "enhanced health in homecare" services**, with careworkers taking on more activities under nurse or other professional supervision, with improved support from GPs, pharmacists and allied health professionals. This has the potential to lead to improved outcomes for people drawing on services, many of whom have healthcare needs. It could also enhance professional development and a sense of professional security, ensuring that care workers feel well-supported despite lone-working.

8. What effect has the COVID-19 pandemic had on adult social care?

8.1 We have observed the following important and inter-related impacts on the homecare sector:

i. **Changes in demand** – demand for homecare has increased; an ADASS survey in May suggested that 16% more homecare hours have been delivered in early 2022 compared to early

2021. Despite this increase, in the first quarter of this year over 2.2 million hours of commissioned homecare were undelivered.

ii. **Staff shortages –** there are not enough careworkers to meet demand. Skills for Care report vacancy rates in homecare still rising – having reached 13.5% in April.

iii. **Costs have increased** – wage costs have increased substantially as competition in the labour market has heightened and homecare is also facing other inflationary pressures, for example, fuel costs which reached new highs in May 2022. Collectively, homecare workers drive over 4 million miles per day and driving is essential to deliver homecare in many communities, particularly in rural areas. In total, providers are experiencing inflationary increases in costs in the order of 10% or more, though most have received only an average 3% increase in fee rates. As well as this creating questions about the sustainability and supply of care paid for by the public sector, people paying for their own care are likely to have seen rising costs.

iv. **Preferences have changed** – the Homecare Association conducted a YouGov survey in 2021 of 2618 members of the public. We found that one third (35%) of the public surveyed reported that they would be more likely to choose care in their own homes as a result of the pandemic. Reasons given indicated that this was more due to the ability to maintain relationships, lifestyle and how much control people felt that they had rather than due to concerns about safety.

v. **Care is getting harder to access** – demand for homecare has increased at a time where vacancy rates are higher than they have ever been and this is resulting in longer waiting lists. The ADASS survey in May indicated more than 500,000 people waiting for assessment, care or direct payments, or reviews.

vi. **Some increased visibility** – the pandemic did draw people’s attention to social care in a way that had not occurred before. For example, we have seen increased press coverage of some of the issues experienced by the care sector during the last two years than was previously the case. We have also seen a White Paper on social care with some reforms, which may not address some fundamental issues, but is progress that the sector has spent years waiting for. Nevertheless, as our earlier answers indicate, there are still issues to be addressed.

Unpaid care and co-production

I. For the most part, we believe that unpaid carers and people using services (or their representatives) may be better placed to answer the questions in the sections on unpaid care and co-production.

J. However, we wished to comment on the question that said "It is often difficult for people who draw on care and support and carers to exercise choice and control if they do not know what good support looks like or what kinds of care and support might be available."

K. While there are examples of good practice and innovation, if the majority of homecare services are commissioned based on time-and-task commissioning; and with extremely restricted budgets it becomes much harder for those providing care to demonstrate innovation and outstanding quality in the services that they provide. This affects both the range of options that might be available to a person (i.e. choice), and quality.

L. A core part of what makes good care is also about people having a good relationship with the careworkers supporting them. Low commissioning fee rates and by the minute commissioning practices do not allow for competitive pay and terms and conditions to be offered to careworkers. If providers are able to hold on to good careworkers who are invested in what they are doing, and happy at work, then this will have a big in pact on quality of care and the ability of people using care services to build a relationship with care staff.

Conclusion

M. In summary, while we can give examples of actions that have increased the visibility of the sector (such as Matthew Taylor's advocacy, the progress that is included in *People at the Heart of Care,* and the increased interest in the sector during the pandemic); much more work is needed for people to understand social care well. Fundamental issues still need to be addressed and there is a need for ongoing engagement from the Government with those who depend on care and support and all of those involved in the sector.

Submitted by Michelle Dumont, Policy Specialist, on behalf of the Homecare Association.