Homecare Association

Comprehensive Spending Review Representation 2021

Submitted 30/09/2021

The Homecare Association (formerly United Kingdom Homecare Association/ UKHCA) is the UK's membership body for homecare providers 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.

Please summarise your representation in no more than 200 words

The homecare sector is not sustainably funded and cannot absorb further costs. 70% of the sector's income is from the public sector and 87% of commissioners are paying less than the *minimum* rate we believe is required for basic compliance with regulations. Staff shortages are the worst anyone can remember at a time when demand is increasing. Poor pay and terms and conditions are limiting workforce capacity. This is closely linked to commissioners paying unsustainable rates.

Based on data from commissioners, obtained via Freedom of Information Act enquiries, we believe that in excess of £1.7 billion p.a. would be required to supplement commissioners' rates across the UK to allow homecare providers to pay competitive wages.

Infection Control and PPE costs must continue to be met. Delivery costs will rise in 2022/23 due to national insurance and wage increases, and high inflation and insurance costs.

The Government must meet the costs of proposed reforms and not rely on the sector to fund these. Vaccination as a condition of deployment (VCOD) requires an impact assessment and must be adequately funded. We strongly support vaccination of the workforce, but advise against VCOD due to the risk of a 20% reduction in workforce capacity.

Executive summary

The homecare workforce is exhausted from 18 months of delivering vital services through a pandemic. With increased competition for staff from the NHS, retail and hospitality and limited ability to increase wages due to the nature of public sector contracts, care providers are now facing critical staff shortages. The proposals announced by the Government, to date, fall short of taking the action we believe is needed to address the needs of the social care workforce and to staff our services.

Amidst the worse staffing shortages anyone can remember, homecare providers across the UK are facing rising demand and the need to maintain infection control costs. Lately, they have also experienced issues with obtaining fuel to maintain service delivery and rising fuel costs. Homecare is playing a critical role in supporting individuals, helping to prevent deterioration and admission to more expensive settings of care, such as care homes and hospitals. Homecare is also a vital component of pathways to ensure smooth flow of patients through healthcare systems. Without adequate capacity in care at home, it is difficult for the NHS to use its resources effectively to reduce the elective backlog. Homecare is also necessary to support informal carers, enabling those with care responsibilities to work and maintain their own health.

The additional £5.4 billion over three years that has been announced (of which, we have been advised, £2.5 billion will fund the care cost cap changes) is grossly inadequate to meet demand or address the root causes of our workforce issues. Though funding has been provided to support infection control costs, this is time-limited, despite the need for these measures persisting into the medium term, making it hard to plan.

We believe that investment in the care sector is needed to 'level up' – for reducing inequalities and avoiding postcode lotteries in access to services. It is needed to help maintain health and well-being of growing numbers of older and disabled people in the community, encourage innovation in public services, and enable the NHS to operate effectively. Social care is vital for many individuals and families to live their day to day lives. Adequate funding of care is not only the fair and right thing to do but this investment will also support the everyday economies of our towns, increase employment, reduce the gender pay gap and improve the quality of life of disabled and older people.

To address our most immediate financial concerns, we are asking the government to ensure:

1. Funding is sufficient to allow for care to be paid at **a fair rate that allows public sector commissioned care providers to pay fair and competitive wages to careworkers**, without reducing the amount of care being delivered. Based on what we know about current fee rates, we suggest that this would cost in the order of £2 billion for the UK for 2022-23 (see proposal 1 for calculation).

2. **Infection Control and Testing Fund remains available** during 2022-23 (and potentially longer, if required), and this should cover additional costs associated with testing, vaccination (including costs associated with the flu vaccination and COVID booster vaccinations) and costs associated with close contacts of cases and those self-isolating not working.
3. If the Government pursues **Vaccination as a Condition of Deployment** in the homecare sector (which we do not recommend at this time), a full impact assessment should be undertaken and any additional costs identified should be met. We anticipate that these costs will be hundreds of millions of pounds and risk increased instability in the sector.
4. PPE costs must continue to be met through one route or another. Our preference would be for the **PPE Portal to continue to provide free PPE** for the next year, or until enhanced PPE is no longer required.
5. The amount provided for social care needs to take into account **inflationary costs** in the next financial year, including **national minimum wage rises** and **national insurance contribution increases.** It is important to note that care sector inflation rates have historically tracked significantly above general inflationary rates (as indicated by the Consumer Price Index (CPI)).
6. Inflation in costs of insurance, fuel, and infection prevention and control are having a disproportionately high impact on the care sector. The Government should ensure that the proposed "fair price for care"[1] contains **a realistic assessment of care sector inflation,** as well as general inflation.
7. The Government should ensure that funding is available to **meet increased demand** for care at home, including meeting pre-pandemic unmet need, recent rises in demand and the likely increased need for care services if the NHS is undertaking additional activity to get through its backlog. (We estimate that this will cost in excess of £14.4 billion for England for 2022-23).
8. **CQC fees should not be increased.**
9. The **costs of the adult social care reforms proposed by the Government must be fully met** without impacting on the availability of funding for frontline care delivery. This includes costs associated with changes to the CQC's remit and the introduction of the care cost cap.

Note that these proposals focus only on the priority concerns which have significant funding implications, and we look forward to discussing reform of the sector more broadly with the Department of Health and Social Care, including our desire to move away from time and task commissioning and develop a credible workforce plan for social care.

[1] We understand that the Government intend to bring forward a White Paper which includes proposals for a 'fair price for care' which will be an agreed fee rate for providers that fully meets the reasonable costs of delivery.

Context

The need to support the care workforce and invest in a stable homecare sector

The two major risks to the homecare sector at present are firstly, the risk of staffing shortages and secondly, the risk of financial instability leading to instability in the market, providers handing back contracts or withdrawing from the market. Before explaining the rationale for our specific proposals, we will outline why the social care sector cannot easily absorb additional costs and which factors are contributing to staffing shortages.

Financial stability

Industry analysts estimate that 70% of homecare providers' business comes via state-funded commissioning of care (LaingBuisson, 2020). Auctioning of care on local authority procurement portals tends to emphasise price over quality, encouraging a race to the bottom. Care providers may feel pressure to undercut each other in order to gain large-volume contracts with local authorities or CCGs. This can lead to fee rates being agreed that are unsustainable in the long term. Local authorities are effectively monopsony purchasers and dictate fee rates for homecare. Once in a contract with a local authority, a provider may have limited ability to negotiate changes to fee rates if costs increase. This means that, while some sectors will increase prices or reduce margins to absorb additional costs, many care providers do not have this option.

As evidence to support this point consider that the National Audit Office (p.30) found that 34% of private sector homecare providers have current liabilities which exceed their current assets. The Competition and Marketing Authority, and others, have documented the fact that there is cross-subsidisation in the care home market from private paying clients to local authority clients due to the local authority rates being artificially low. There has been less analysis of the homecare sector, but the dynamics of the sector are similar enough and many homecare providers, particularly but not exclusively small and medium enterprises (which comprise 85% of the market), are relying on cross-subsidisation in a variety of forms.

Over the summer of 2021, we made enquiries under the Freedom of Information Act to 340 public bodies across the UK with responsibility for commissioning and purchase of homecare. Data from this reveal that of the 281 local authorities and health bodies commissioning homecare across the UK, 245 (87%) were paying below our minimum price for care of £21.43. We emphasise the word *minimum*, as this figure assumes that it is possible to recruit and retain staff at the legal minimum wage.

Employers are reporting heightened competition in tight labour markets, where homecare work often involves a higher level of skills, training, responsibility and personal risk than some of the other roles offering similar or higher wages. Our *minimum* price is intended to estimate the fee rate required to cover all costs of running a homecare agency, including direct staff costs (pension, national insurance, holiday and sick pay, travel and mileage) as well as other costs of running a homecare business (for example, management, supervision, training, recruitment, PPE and consumables, insurance, regulatory fees, IT, telephony, rent, rates, utilities, business administration and so on). Fee rates paid below this rate are unlikely to enable growth and development of the workforce and delivery of good quality care in a financially sustainable manner. This means that at least 87% of public sector commissioners are paying unsustainable rates.

Earlier this year, the National Audit Office suggested 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". With sustained budget pressures, it is not always guaranteed that funding allocated to local authorities will be used for social care and not other priorities. Social care providers have sometimes found that funding provided to local authorities has not always reached them or been fairly distributed to all the providers in the area. This can mean that access to funding varies greatly across the country. A case in point would be the Infection Control Fund round 1, where we found that some local authorities in England did not provide any funding support to domiciliary care, some provided support only to providers contracting with them and others did provide support to the whole sector. Meanwhile, unringfenced funding may be used for any other activity that the local authority undertakes, whether that is road maintenance or planning applications. This may highlight the need, in the context of local authorities being short on funding, for social care funding to be ring-fenced with clear guidance on its distribution. It also highlights that access to social care funding (both in terms of hourly rates paid for public sector commissioner work and access to emergency funding) can vary significantly across the country. This does not align with the Government's manifesto aim to 'level up', as we observe the lowest fee rates for homecare in the areas with highest levels of deprivation.

If providers cannot cover their costs there is a risk that they will hand back contracts, not take on additional work or close down in more extreme cases. Even organisations that are minimally impacted may be less likely to invest in improving care quality, developing their service or operational systems.

If providers hand-back or refuse to take on more care, this impacts local authorities' ability to commission care and the total capacity of the market. Care provider failure is likely to be more pronounced in areas where funding is spread more thinly, and this risks the creation of 'care deserts' (a concept previously explored by Incisive Health for Age UK in 2019) – areas of the country where provision is lacking.

The rapid survey undertaken by ADASS in September 2021 suggested that capacity in the homecare sector had actually increased by 4% between spring and summer this year, but was not rising fast enough to meet a boom in demand. This had a number of effects including 13% of people being offered care and support such as residential care, that they would not have chosen, and which is likely to be more expensive, due to recruitment and retention issues amid longer waits for support.

Some providers are also handing back contracts or closing. Earlier this year, Hft's Sector Pulse Check found that 62% of providers had to close down some parts of the organisation or hand back marginal contracts and services to their local authority over the past year (i.e. during 2020), compared to 45% the previous year (2019). 51% of providers were considering doing this in the near future. Note that this was before staffing pressures increased. The ADASS Activity Survey, 2021 suggests that about half (53%) of local authorities had experienced this in the six months prior to the survey (October 2020 to March 2021). This was slightly lower than the prior six months where 60% of local authorities had reported this, but again, staffing pressures began to significantly affect the sector after this period, over summer 2021, and we would expect more council's to be experiencing issues in accessing care this autumn, compared to earlier in the year.

In summary, high levels of demand do not promote growth or stability in the sector if fee rates remain unsustainably low compared to costs of delivery, and while other factors, such as staffing shortages, are limiting growth.

Spending on the care sector should be viewed as an investment rather than an expense. The care sector employs over 1.5 million people and contributes £41.2 billion to the economy in England alone (Skills for Care).

Care services are vital to the quality of life of the people they support. Availability of high-quality care services allows informal carers to access employment, participate in the community and take time to support their own wellbeing. In 2019 Carers UK estimated that 600 people a day were giving up work as a result of caring. This figure is likely to rise if there are shortages of paid-for care services.

The fact that the funds raised by the national insurance increases, under recently announced reforms, will be allocated primarily to the NHS suggests a lack of parity of esteem between the NHS and social care. It also suggests a lack of understanding of the dynamics within healthcare systems. Social care and the NHS are closely connected and demand for social care has also seen a delayed boom due to the pandemic, as with the NHS. In the early part of the pandemic, we were hearing reports of fewer packages of care being commissioned. As the recent ADASS Rapid Survey results suggest, we are seeing a post-pandemic boom in demand for social care.

Many NHS trusts cite high occupancy and difficulty in accessing homecare, which results in people who are medically fit for discharge being stuck in hospital for longer

than necessary. One NHS doctor told us that one ward of 30 patients deemed medically fit for discharge but awaiting care at home, took up 30 beds, 4 doctors, 3 consultants and a plethora of nursing and supporting staff. This also means that doctors cannot focus on clinics, which leads to increased waiting times. The longer people stay in hospital when medically fit for discharge the greater the chance of hospital acquired infections, primarily urinary tract infections and hospital acquired pneumonia. This can result in further deterioration, requiring even more support at home. When scaled up across every hospital, the impact is substantial.

The NHS will struggle to create the bed capacity to address its backlog if social care is not funded to meet an increased demand, including support for hospital discharges of those on the elective surgery waiting lists and for post-COVID patients. We have not been able to obtain data on recent delayed hospital discharges in England, though we believe it would be in the public interest for this to be published and would encourage the Government to begin publishing these figures again. We suspect that these figures would show that limited capacity in social care is having a significant impact on hospitals by causing a bottleneck effect.

In summary, there remain significant concerns about the financial viability and stability of some parts of the care sector due, in a large part, to public sector commissioning practices. While demand is booming, it is proving difficult to expand to meet that demand. Investment to provide the support that is needed will have a positive impact on those receiving care, their families and the workforce. Provider failure can have significant adverse consequences for those receiving care, their families and regional services (including the NHS).

Staffing

The current staffing shortage in homecare has multiple and complex underlying causes. It has been significantly affected by Government policy, including the implementation of the Skilled Worker Visa (while the proportion of careworkers from the EU was low apart from in some subsectors, like live-in care, this has created shortages elsewhere in the labour market, increasing competition for staff). The announcements about vaccination as a condition of deployment, whilst only under consultation in the homecare sector, may also deter staff from taking up roles.

At the root of the issues, however, is the fact that employers of careworkers cannot offer wages and terms and conditions that compete with other sectors, including retail and hospitality, or provide differential salary structures which allow career pathways to be developed. This is so even though care work is highly responsible and skilled work that requires training, commitment, and excellent communication and inter-personal skills.

Without staff, the sector's capacity is limited and this has significant implications for the wellbeing of those waiting for care, as well as for the NHS's ability to discharge patients in a timely manner.

Skills for care's vacancy rates show a steady increase in vacancies in domiciliary care with vacancies having reached 11.3% in August 2021.

We surveyed our members in August 2021. We received responses from 843 homecare providers.

Key findings were as follows:

- 95% of homecare providers said that recruitment was harder than before the COVID-19 pandemic, with the majority (78%) saying that recruitment was "the hardest it has ever been". There were not substantial regional differences.
- Providers serving predominantly the private-pay part of the market reported similar challenges to those serving predominantly the state-funded part of the market.
- 65% of homecare providers said that more careworkers were leaving their jobs than before the pandemic, including 29% who said that more careworkers were leaving than ever before. Just 4% said that fewer careworkers were leaving than before the pandemic.
- 89% of providers stated that demand for their services had increased or significantly increased over the previous two months. Just 2% said that demand had reduced or significantly reduced.
- Careworkers' pay and available terms and conditions of employment were said to be the greatest challenge to recruiting and retaining homecare workers, with 46% of employers describing that as the most significant issue. This is, of course, closely linked to how the homecare sector is funded by the State, and what private individuals arranging their own care are willing and able to pay. Consistent patterns were seen across regions, with some variation.
- 38% of providers said they were unable to take on new work, with 57% saying they could take on some but not all new work.
- 29% of providers said they were handing some work back, with 1% saying they were handing all work back. 70% were continuing to meet existing need.
- The recruitment situation is dire at the moment, with multiple factors contributing to this.

To address the issue, the Government needs to act to ensure that the sector can offer fair and competitive wages to staff.

The need to increase staff wages is against a backdrop of many careworkers, as part of low paid families, being up to £1000 worse off per annum (according to the

Resolution Foundation) due to inflation, the changes in Universal Credit and the National Insurance Contribution increases.

Other factors affecting staff motivation to undertake care work should also be considered. Most public sector commissioning of care focuses on the amount of time that a care worker spends with the person that they are supporting, rather than on what the recipient needs and wants from the support that they get – with very little flexibility or concern for outcomes. Time and task-based approaches to commissioning can be demoralising for care staff who want to be responsive to the needs and requests of the people that they support. The Government should further explore commissioning for outcomes and the use of arrangements such as Individual Service Funds. This is relevant to the quality of service, but also to careworkers' job satisfaction.

Recently, the added question of access to fuel has arisen. The mobile homecare workforce is highly dependent on access to transportation, at reasonable cost, in order to meet people's needs and ensure that the people they support are safe. We have called for priority access to fuel for care staff.

The Homecare Association continues to call on the government to:

- Fund social care adequately so that homecare workers are paid fairly for the skilled roles they perform, and at least on a par with equivalent public sector roles.
- End the practice of councils and the NHS of purchasing homecare "by-the-minute", alternatively focusing on achieving the outcomes people want.
- Support development of an expert-led workforce strategy for social care and a 10-year workforce plan, aligned with the NHS People Plan.
- Create a professional register for careworkers in England, covering all paid social care workers in both regulated and unregulated care services. Registration of careworkers needs to be adequately funded and carefully implemented.

Changes planned

The Health and Care Bill (which is at Committee stage at the time of writing) includes some elements related to social care, including proposals to make direct payments to care providers in emergency situations, to obtain better data on social care, and to evaluate local authorities' delivery of their duties with regards social care via CQC review.

In September 2021, the Government published Build Back Better: Our Plan for Health and Social Care announcing an additional £5.4 billion funding for social care over the next 3 years. The threshold for means-testing will be increased and a care cost cap

introduced. Those funding their own care will be able to ask a local authority to arrange it on their behalf, to secure better fee rates.

The Government has also stated that it will be bringing forward a White Paper on social care which will incorporate something on a 'fair price for care', and that this should help to address issues of cross-subsidisation. This will be critical if more local authorities are purchasing care on behalf of self-funding recipients of care, under section 18(3) of the Care Act 2014. As outlined above, parts of the sector currently rely on cross-subsidisation so unless local authorities are paying a sustainable rate this could cause financial failure for care providers.

We believe that the changes announced so far are grossly inadequate to address the current staffing issues that we are experiencing or to stabilise the sector financially.

We understand that £2.5 billion of the new funding will fund the changes in the care cost cap and savings threshold. This leaves £2.9 billion over three years for system reforms (i.e. less than £1 billion per year).

£500 million (over three years) is for careworker training and wellbeing. While any funding is certainly to be welcomed, with a workforce of around 1.5 million, this amounts to little more than £100 per careworker per year so is unlikely to provide a substantial incentive to join or stay in the sector if wages remain uncompetitive (and providers are unable to offer better wages without better fee rates from public sector commissioners). The incentive to undertake training is also lower if there is no reward in terms of pay increments or career prospects for a higher level of training.

This leaves £2.4 billion to cover any remaining reforms, including, we understand, the Government's 'fair price for care'.

To put this in perspective we estimate (further details below) that a fair price for care, allowing for better and more appropriate and competitive pay and terms and conditions for careworkers, would cost something approaching £2 billion per annum for the UK as a whole (i.e. £5 billion to 6 billion over three years; or around £4 billion p.a. for England alone – see proposal 1 below) and that it would cost over £11.7bn per annum to meet unmet demand for social care in England (i.e. more than £35bn over three years, see proposal 7 below) or over £14.4bn per annum if a wage were to be paid, equivalent to an NHS Band 3 rate (i.e. in excess of £43.2bn over three years).

Meanwhile, ADASS argue (ADASS Activity Survey 2021, p11) that Directors of Adult Social Services have been required to find £7.7 billion in savings from Adult Social Care budgets over the 2010-2020 period.

Even if, in the long-term, a higher proportion of the national insurance contribution increase is used to fund social care there is an immediate funding gap between current spending and both delivery costs and demand.

In summary, the funding that will be made available under current government plans is grossly inadequate.

Social Care Precept

A further point worth noting is that social care funding has been tied to local authorities being able to raise funds through a 'social care precept' (i.e. an increase in Council Tax).

Many councils have been reluctant to increase council tax. In some cases this is due to the concern about the tax burden on local residents. This year, they may also be reluctant to increase council tax to fund social care when national insurance is increasing for that purpose also. Ultimately, we would expect that not all councils will raise taxes creating a mixed funding picture across the country.

Council tax income also varies depending on the wealth of the region in question. Need will vary depending on the demographics of the constituents. A council tax increase will result in higher tax revenue in wealthier regions, but there may be higher demand for care in less affluent parts of the country. This means that relying on a social care precept may further ingrain regional inequalities in access to and quality of care – in direct opposition to the Government's stated intention to 'level-up'.

We would not recommend increasing (or removing) the cap on the social care precept as a mechanism to fairly address social care funding issues.

Conclusion

We want a future in which people can access high quality care at home. In a recent YouGov survey we conducted, 9 out of 10 (88%) of over 65s agreed with the statement "People would prefer to be supported at home rather than in a care home". If the homecare sector is going to be able to expand to deliver the care and support that people want, expect and deserve then long-term solutions are needed to ensure that care providers receive sustainable fee rates that are sufficient to pay fair and competitive wages to their staff.

Key policy proposals

Fair price for care, allowing for competitive wages

Proposal 1: The Government should invest around £2 billion per annum to ensure that homecare providers are paid a sustainable and fair rate for care that allows for careworkers to be paid a fair wage, reflecting the skill and experience necessary.

The Government must introduce a compulsory minimum rate for purchasing care services that is fair and sustainable and which public sector commissioners should not drop below. This must be funded and should include consideration of ensuring that levels are sufficient to support fair wages and pay structures for careworkers (as has been argued by others, for example Anthony Collins Solicitors). We understand that the Government is considering such a policy measure in the form of a 'fair price for care', which will be included in a future White Paper.

Over this summer we have gathered data on fee rates being paid to homecare providers by public sector commissioners across the UK (including NHS and local authority commissioners). There is significant variation across the country, but the weighted average hourly rate being paid to providers this year was £18.57.

The Homecare Association calculates a *minimum* price for care which estimates what minimum hourly rate a homecare provider requires to provide quality care, cover their business costs and operate sustainably, meeting all legal requirements. This estimates both direct careworker costs (pension, national insurance, holiday and sick pay, travel and mileage) and other operating costs (including management, supervision, training, recruitment, PPE and consumables, IT, telephony, insurance, regulatory fees, rent, rates, utilities, general business administration and so on). You can find the full details of this model at: A Minimum Price for Homecare (April 2021 to March 2022) - Report (homecareassociation.org.uk)

For 2021/22 this rate has been calculated at £21.43 per hour. However, we do not believe that the minimum wage (i.e. the National Living Wage), which this is based upon, is a fair rate of pay for careworkers. In the present recruitment environment, it is also not a competitive rate of pay, which means the minimum price may not be viable.

At the Real Living Wage (£9.50 per hour), our costing model would calculate an hourly rate of £22.73 (or £10.85 / £25.70 per hour in London), it is questionable whether this is competitive. We know that in some parts of the country providers paying higher than this rate, such as £12.50 per hour, are having difficulties recruiting.

A third point of comparison would be if a careworker were to be paid the equivalent of an NHS Band 3 Healthcare Assistant with two years' experience (around £11.14 per hour based on a 37.5 hour working week). Our costing model would calculate an hourly fee rate of £26.31 based on this wage.

Of the 281 local authorities and health bodies across the UK who provided an average hourly price in response to our survey, 245 (87%) were paying below our Minimum Price of £21.43 per hour.

Based on the information we have gathered (yet to be published) we estimate that to fund a "Fair Price for Care" *for the UK as a whole*[2]:

- £0.6 billion extra per year for homecare alone would be required if it was assumed that care providers could function paying careworkers the minimum wage (i.e. the National Living Wage, this is becoming increasingly unlikely and does not reflect the skill, responsibility or risks that careworkers face). This would be £0.5 billion for England alone.
- Just over £1 billion would be required if the Real Living Wage (or London Living Wage) were to be paid to care workers. This would be £0.8 billion for England alone.
- £1.7 billion would be required if careworkers were to be paid the equivalent of Band 3 NHS staff. This would be £1.3 billion for England alone.

Funding would also be needed to implement a fair price for care across all local authorities. Higher hourly rates would be required to recognise and reward the more skilled work of carers who are delivering complex care packages. For this reason, we would recommend investment in excess of £1.7 billion and assume additional costs would be closer to £2 billion than £1 billion per year across the UK.

Note that this figure is also based on 2021/22 figures and does not include inflationary factors that will affect the unit costs in 2022/23, which are discussed below in proposals 4 to 6.

It will be difficult to address the sector's staffing shortages without being able to offer more competitive wages. Staffing levels will directly impact the capacity and stability of the sector.

Continuation of the Infection Control and Testing Fund

Proposal 2: The Government should ensure that the Infection Control and Testing Fund remains available during 2022-23, and this should cover additional costs associated with testing, vaccination and costs associated with close contacts of cases and those self-isolating not working.

The Infection Control Fund has been vital in helping care providers to meet some of the additional costs associated with the pandemic, including supporting staff to self-

[2] These figures are based on around 221 million hours of homecare being commissioned from the independent sector by the public sector for the year. Local authority commissioning figures are discussed in our Market Overview. NHS commissioning figures were based on the data from our Freedom of Information requests.

isolate and access routine asymptomatic testing. Cost pressures that are likely to be extremely important over the next six months include:

- Costs associated with supporting staff to get the COVID booster vaccine and flu vaccine (and first and second doses of the COVID vaccine if not received yet). Staff will need to take time away from work in order to travel to appointments and to receive the vaccines. Careworkers should be renumerated for this, but the cost of doing so is unlikely to have been factored into hourly rates.
- Funding to support staff time spent on PCR testing in homecare was left to local authority discretion last time that the guidance was revised. During the first round of the Infection Control Funding we saw significant variability in approaches by local authorities. With a focus primarily on care homes, only some local authorities supported all homecare providers in their areas; some only supported homecare providers with whom they contracted and others did not provide any support to the homecare sector (as is evidenced by the Local Authority Spending of the Infection Control Fund spreadsheet). For this reason, we would recommend ensuring that guidance is clear that testing costs should be covered and not left to local authorities' discretion.
- The implementation of section 2.5 of the COVID-19: management of staff and exposed patients or residents in health and social care settings guidance has created a funding gap. Previously, it would have been possible for those who were legally required to self-isolate to access various forms of financial support, or for employers to make claims from the Infection Control and Testing Fund. Now there are situations where fully vaccinated staff who are contacts of positive cases are not legally required to self-isolate, but do need to isolate under the guidance (for example, because it is unavoidable that they work with highly vulnerable people). The guidance does not clearly state what funding route is available to support these people while they are not working. We have been advised by the Department of Health and Social Care that the ICF should cover these costs.
- Decisions to extend funding have tended to be last minute and on a quarterly basis. Short-term and short-notice decisions make it very difficult for providers to plan effectively. We would support a more medium-term extension of this funding, as the measures required are unlikely to be removed, at least before next summer.

Due to cost pressures (outlined above), removal of emergency funding while infection control and testing measures are still required jeopardises care providers' ability to implement measures, keep staff and service users safe, and meet regulatory, legal and insurance requirements. Emergency funding is important in avoiding providers' financial failure at a time when the country cannot afford to lose homecare capacity.

Vaccination as a condition of deployment (VCOD)

Proposal 3: If the Government pursues Vaccination as a Condition of Deployment, a full impact assessment should be undertaken and any additional costs identified should be met; we estimate that these will be hundreds of millions of pounds.

We would like to highlight that while we support and encourage uptake of both the COVID and flu vaccination, the Homecare Association believes that the implementation of COVID-19 vaccination as a condition of deployment in homecare would lead to critical staff shortages in some areas. The addition of mandatory flu vaccines to this may further aggravate the situation. We intend to respond to the current consultation that is open with our full views on this matter.

DHSC's own cost estimates suggested that VCOD in care homes might cost £100 million in recruitment costs alone (and this includes a reduction of Skills for Care's estimated cost). This does not include:

1. Costs of dismissal and payment of statutory notice periods. While some careworkers may resign, and care providers may be able to issue staff with notice or conditional notice during the lead up period to the legislation coming into force, some care providers may still find themselves faced with careworkers who are not fully vaccinated by the deadline and may need to pay staff for their statutory notice period while not permitting them to work.
2. Human Resources and legal advice costs associated with discussions with vaccine hesitant employees.
3. Potential employment Tribunal claims against employers, which could cost some employers (who were following Government legislation) tens of thousands of pounds in legal defence costs.
4. Cost to local authorities of finding last minute cover.
5. Cost to the NHS of not being able to discharge hospital patients, if providers are understaffed and unable to take on care packages.
6. Increased wage costs in order to attract new staff in today's labour market.

It is likely that staff shortages would significantly affect the capacity of some care providers, meaning a reduction in business and turnover. This in turn could impact on the viability of certain business models and/or drive up the unit cost for delivery due to decreased volume of work delivered.

It is also true that the impact on providers and local authorities would not be evenly felt across the country. Regions with lower vaccination rates (typically major city centres, such as Birmingham, Manchester, Newcastle, Leeds and London) are likely to see care providers in serious difficulties if a higher proportion of their workforce are vaccine hesitant. Within those areas it is also likely that some care providers will be

affected more substantially than others. The potential impact of mandatory vaccination will be very different for providers for whom 4% of the workforce is hesitant, compared to those for whom 40% of the workforce is hesitant. Losing a significant proportion of the workforce is likely to lead to a need to revise an organisation's business model and reduce the amount of care being delivered which comes with significant costs, as well as long term losses in income and a significant human cost to those being supported and staff. As a result, some businesses may decide to close, reducing the capacity in provision in some areas when the sector is already struggling to meet demand.

PPE costs

Proposal 4: PPE costs must continue to be met through one route or another. Our preference would be for the PPE Portal to continue to provide free PPE in England for an additional year, or until enhanced PPE is no longer required.

As discussed above, PPE continues to be required for infection control at a level that was not previously seen and most care providers:

- may not be able to straightforwardly increase prices to cover PPE costs where working under a local authority or NHS contract;
- do not have the margins to absorb cost increases; and
- local authorities have a track record (in the case of minimum wage increases etc.) of not increasing fees at a rate that reflects the actual increased costs to providers.

It follows that for care provision to continue to be sustainable the cost of PPE must be funded.

Our preference would be for a continuation of the existing system (the PPE Portal), which seems to work for most providers after an extensive process of refinement.

We would be concerned that if, as an alternative, local authorities were provided with un-ringfenced funding to pay providers a higher overall fee rate in order to cover PPE costs, that this would not consistently reach providers across the country due to council budgetary pressures. It would also, potentially, mean increased administrative costs for providers to source the PPE that they need. There is an added risk that funding may not keep up with changing PPE guidelines or requirements or price fluctuations.

DHSC would be best placed to estimate the current costs associated with the operation of the PPE Portal in relation to social care. If guidance changes to favour more expensive PPE items (for example FFP3 masks) then PPE costs will increase, and providers will face additional costs associated with fit testing.

The current system ensures that care providers can consistently access the PPE of the quality and type that they need, regardless of their locality. In turn this enables service delivery (since providers would face regulatory, legal and insurance issues if they did not follow PPE guidance) and reduces infection risk to service users and staff.

Inflation and wage costs

Proposal 5: The amount provided for social care needs to take into account inflationary costs in the next financial year, including national minimum wage and national insurance contribution increases.

We are particularly concerned about cost increases in the following areas:

1. While CPI saw prices rise 3.0% in the twelve months to August 2021 this figure may increase further if there are ongoing staffing and transportation issues in the wider economy. This will impact homecare providers who rely on fuel to support the mobile workforce as well as infection control, office and other supplies whose costs might increase.
2. Aside from this, wage related costs could increase significantly, if minimum wage were to increase 5.7% to £9.42 (as estimated by the Low Pay Commission). Though there would be less of a direct relationship to care costs if commissioners paid rates that allowed for a wage above the minimum rate (see proposal 1).
3. National Insurance contributions will rise by 1.25% for employers and 1.25% for employees, with obvious cost implications for the sector. As a significant proportion of the homecare workforce are likely to fall below the earnings threshold, we would anticipate that this is likely to increase wage related costs further across the sector by 0.7% (noting that this will apply to training, annual leave and so on as well as contact time).

If fee rates are not increased to reflect these costs, then care providers will have difficulties covering their costs, which could limit or reduce the capacity in the market.

Note that our calculations in proposal 1 regarding a fair price for care do not incorporate the impact of these increases.

Insurance

Proposal 6: The Government should ensure that the fair price for care contains a realistic assessment of the cost of insurance.

Our recommended insurance brokers have previously advised us that they are seeing increases in premiums of up to 50% in some parts of the market (though we have heard of anecdotal cases in excess of this). Some insurers have also withdrawn or limited the extent of public liability cover offered in response to the pandemic.

This means increased risks and costs for care providers and may discourage providers from supporting hospital discharge of individuals with coronavirus. We have raised this issue with the Department for Health and Social Care and H.M. Treasury repeatedly. We undertook a survey of providers earlier in the year with the British Insurance Brokers Association.

Key findings from the survey were:

- There were, currently, only two companies providing insurance services to new business in the sector - a cause for concern.
- 10% of care providers had less cover than before.
- 35% of care providers had COVID-19 and/or other communicable disease exclusions from Public Liability cover.
- 72% of care providers had seen their premiums rise.

We note that the Department, following pressures earlier in the year (for example, see Financial Times, 2021) launched a Designated Settings Indemnity Support scheme for care homes (NHS Resolution, 2021).

The Government has also provided insurance support for events operators amounting to £750 million.

However, even though hospital discharge is often to the community rather than care homes, and this is critical to the wellbeing of the public and operation of the NHS, there is currently no indemnity support to cover homecare providers.

If there are significant staff shortages, we anticipate that it will become harder for providers to receive 'Good' and 'Outstanding' CQC ratings when they are inspected. We are particularly concerned that providers who receive a 'Requires Improvement' rating from the CQC may find it hard to renew their insurance which could lead to business closures. The reduced access to insurance could, therefore, compound difficulties in the sector.

We continue to call on the Government to address this issue.

Increased demand for care services

Proposal 7: The Government should ensure that funding is available to meet increased demand for care at home, including meeting pre-pandemic unmet need, recent rises in demand and the likely increased need for care services if the NHS is undertaking additional activity to get through its backlog.

We have previously calculated that if each person with unmet need received 1 hour of homecare per day, every day, at the Homecare Association Minimum Price for Homecare of £21.43 per hour (Homecare Association, 2020), the cost would be £7,828 per year per person. Multiplied by 1.5 million people in England (Age UK, 2019), this would cost an additional £11.7 billion per year in England alone.

If an equivalent of a Band 3 NHS wage were allowed then the hourly rate required would be £26.31, resulting in an annual cost of £9,610 and for 1.5 million people this would cost £14.4 billion per year in England alone.

Note that this doesn't take into account 2022/23 inflationary pressures on unit costs outlined in proposals 4-6 above.

1 hour of homecare per person per day would fall below the standard definition of "intensive homecare" of 10 hours per week.

We know that demand has risen since Age UK calculated its 1.5 million figure in 2019.

We have heard of many NHS hospitals declaring OPEL 4, yet delayed discharge figures remain undisclosed. We believe it would be in the public interest to disclose these. We suspect that delayed discharge to social care is aggravating existing pressures.

Meanwhile, ADASS reported this month that hundreds of thousands of people were waiting for social care assessments and the number of hours that there was not the capacity to deliver had doubled over the last six months – even though the amount of homecare hours delivered had actually increased by 4%. 13% of people were being offered care and support, such as residential care, that they would not have chosen, due to recruitment and retention issues.

As demand is outstripping our ability to recruit, Homecare Association members have reported that they are turning away care packages, with 38% saying that they were unable to take on new work and 57% saying they could take on some, but not all new work.

Everything is pointing towards heightened levels of unmet need. The £5.4 billion in funding that has been announced over the next 3 years (i.e. 1.8 billion per year) is inadequate to meet this level of need when we anticipate that in excess of £11.7 billion per year is required (i.e. in excess of £35.2 billion over three years) or £14.4 billion per annum if a more appropriate wage is paid (i.e. in excess of £43.2 billion over three years).

Without providing funding to meet demand for care services, people will lack the care and support that they need to get by, increased pressure will be placed on families and other informal carers and it will increase pressure on the NHS.

CQC fees

Proposal 8: CQC fees should not be increased, and the Government should cover any additional CQC-related costs that arise.

During the pandemic the CQC has continued to levy fees for homecare providers despite not carrying out inspections to the same level. Providers are still experiencing

delays when interacting with the CQC. This can adversely affect their businesses if they are unable to register their companies or demonstrate improvement in standards to increase their rating promptly. A provider's CQC rating has a substantial impact on costs of insurance.

CQC fees have not been increased for the last two years. If the CQC requires additional funding this year to cover its expenses, we suggest that this is covered by the Government.

This is for a number of reasons. Firstly, a well-regulated sector is in the public interest. Secondly, providers are already being paid fee rates which don't reflect their costs by public sector commissioners and fee rates may not increase to reflect increased CQC fees. Thirdly, we believe that the Government should take a more active interest in the activity of the CQC, increased public funding might also increase public accountability. Lastly, if there is to be greater parity of treatment with the NHS, the regulatory costs of the NHS Trusts are ultimately met by Government.

In addition to this, the CQC have played a key role in collating data for the Government about the social care sector during the pandemic. Data collection is also proving to be central to the CQC's new strategy. We believe that homecare providers have faced costs of around £8.6 million annually in providing data returns of various kinds (assuming managers from 10,500 homecare providers spend 10 days a year on data collection at £82 a day). We suggest that data requests are streamlined and the value of aggregated data (like Capacity Tracker) to Government is recognised.

Cost of implementing Government reforms

Proposal 9: the costs of the reforms proposed by the Government must be fully met without impacting the availability of funding for frontline care delivery. This includes changes to the CQC, data and the introduction of the care cost cap.

The proposals already announced in the Health and Care Bill and the funding changes announced this month have potential costs that could directly and indirectly affect care providers. It is possible any proposals included in the upcoming Social Care White Paper may also generate costs. We ask the Government to ensure that these costs are met without the cost resting on care providers or reducing the availability of social care.

In particular, we are concerned about the following costs:

- The administration of the care cost cap announced in the September funding proposals will require significant IT development and local authority administration costs to establish and operate. This must be funded and must not reduce the funding available for the actual delivery of care.
- If more local authorities are to be encouraged to purchase care for clients under section 18(3) of the Care Act 2014 (as suggested in the funding proposals

announced this month) this may have a significant effect on care providers whose business model may rely on some degree of cross-subsidisation. We believe that cross-subsidisation does happen within the homecare market but that, as well as private to state-funded client cross-subsidisation, this can be complex, with businesses relying on income streams derived through other strands of activity such as housing provision or delivery of different forms of care. It is vital that costs are not driven to unsustainably low rates. We estimate that the cost of removing the cost of cross-subsidisation for homecare would be at least £1 billion p.a. and more realistically closer to £2 billion (see proposal 1).

- The Health and Social Care Bill contains a proposal for the CQC to provide assurance for local authorities' delivery of their duties under the Care Act 2014. Currently the CQC is largely funded through fees paid by care providers. We believe that the Government should fund the review of local authorities directly, and not seek to fund this through increasing providers' CQC fees. Were the CQC to increase costs, this would lead to an unfunded expense. While we have been told that this will be funded by the £5.4 bn, we are concerned, as outlined above, that this funding will not be sufficient to cover all of the changes required to implement the reforms.

As explained above, if the cost of reforms falls on independent providers they do not have the ability to absorb significant costs and this will contribute to instability in the market. In turn this would hinder the Government's ability to deliver strong and innovative public services

Conclusion

The Government's current proposals will do little to address the crisis situation that workforce shortages and the boom in demand for social care is creating. We call on the Government to invest significantly in social care – not at some point in the future, but now. Without additional funding the care sector will struggle to attract and retain homecare staff; and it will not be able to meet demand for services.

The Government must act to assist social care to ensure the wellbeing and dignity of its citizens, and to protect the NHS.

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