COMMUNITY FIRST SOCIAL CARE

CARE IN PLACES PEOPLE CALL HOME

Chris Thomas

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About and acknowledgements

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The Institute for Public Policy Research (IPPR) is the country's preeminent progressive think tank. This paper fulfils IPPR's charitable objective of alleviating disadvantage linked to ill-health.

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INTRODUCTION

The government has created a sense of great anticipation around social care reform. In his first speech as prime minister, Boris Johnson made it one of his top priorities on the steps of Downing Street. Shortly after, the 2019 Conservative manifesto contained a commitment to a consensus-driven and lasting solution for the sector. Having won the election, the government has since confirmed that a specific plan for reform will be brought forward by the end of 2021.

Recent discourse on social care policy has focused on funding. IPPR and Policy Exchange - respectively the leading centre-right and progressive think tanks – have previously jointly recommended free personal care, funded through general taxation [Quilter-Pinner & Sloggett, 2020]. Other proposals have ranged from cost caps to hypothecated taxes (see Box 1).

Additional funding for social care is important. The system has suffered significant cuts and cannot be improved without a funding deal. However, this is not the only question that needs answering. A genuinely successful social care strategy also needs to ask what state-funded care should look like, do and achieve. That is, it needs to ask how social care can actually support people to lead the best possible lives, based on what's important to them.

Without a specific plan for this, the government risks spending large amounts of state money on making a system that doesn't work for the people who use it more accessible or more affordable. No funding proposal constitutes a fully formed vision for a sustainable social care future (though some proposals, like free personal care, get closer than others). As Figure 1 shows, there are four key challenges within social care:

Box 1: Social care funding proposals [from Watt et al, 2018]

Extra funding: Maintaining the status quo but increasing the level of funding, with a hope of addressing unmet need and quality through increased funding, but maintenance of the status quo.

The cap and floor: As proposed by the Conservative Party in 2017. People would pay for their care until their assets reached a certain threshold, with a cap on lifetime costs.

Integrated budgets: A joint health and social care budget. While not a way to increase funding, this is often viewed as a way to mobilise the efficiencies better social care could offer the NHS.

Free personal care: A policy of making personal care, free at the point of delivery, in line with the delivery principles of the NHS.

Hypothecated tax: A dedicated tax to fund social care. This could be ringfenced funding (hard hypothecation) or a more symbolic gesture (soft hypothecation). It could be targeted at some groups (e.g. over 40s) or the whole population.

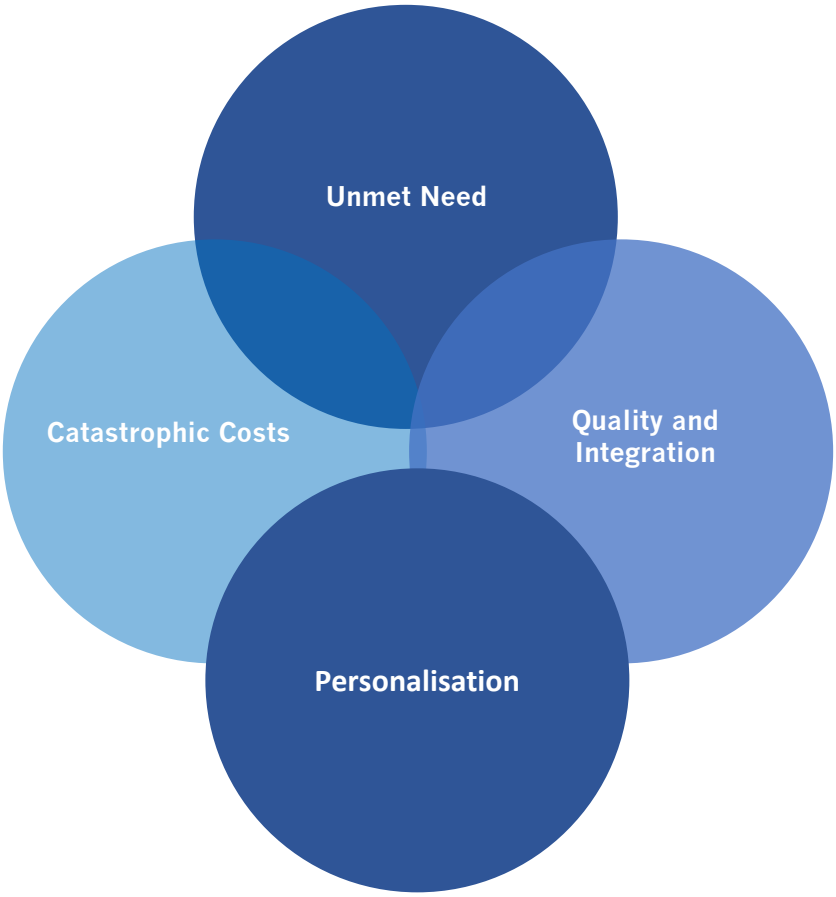
Unmet need: Unmet need ranges from 41 per cent (most deprived areas in England) to 19 per cent (least deprived areas in England) [Burchardt, 2021]

Care costs: Approximately 143,000 older people face 'catastrophic lifetime costs' of £100,000 or more. [Independent Age, 2018]

Quality and integration: Legislation in the 1940s embedded an artificial divide between health and social care, in terms of funding model, public/private provision and eligibility.

Personalisation: Deliberative research shows care is often done to people, rather than with them – meaning a lack of personalisation that impacts quality. [Social Care Future, 2021]

Figure 1: Four key social care challenges



Source: Author's Analysis

The different options for funding reform answer some of these to different degrees – with free personal care an option with several key advantages (see appendix 1 and 2). But there is no silver bullet, nor does any individual option fully meets the Prime Minister's stated ambition that no-one need sell their home to pay for care *and* that everyone should have access high quality dignified support. As such, the success of forthcoming government policy – and the extent to which it constitutes a genuinely sustainable and lasting solution – will rely on more than the funding mechanism

chosen by ministers. It will also be dependent on their vision for how social care empowers people to live with as much independence, connection and dignity as possible.

This briefing makes a contribution to the evidence and policy thinking on what should come alongside funding proposals. It outlines how combining funding reform with a strategic shift of care into the community – as currently being pursued by President Biden in the US – could provide this government with a more sustainable and lasting social care reform agenda. We call this **Community First Social Care** – anchored in care in the places 'people call home'. More specifically, this briefing outlines the value of community care, how a shift to the community can be personalised and empowering, and the role of community care in levelling-up.

THE CASE FOR COMMUNITY-FIRST SOCIAL CARE

The evidence suggests that a more community-led model of adult social care would have several benefits. Community-led care is defined as a system where preventative, proactive community or home based interventions are the norm – as opposed to the current system, which too often waits for people to deteriorate before providing the right support.

> **Personalisation**: Deliberative research shows people would prefer to receive social care support in a place and community they call home – rather than in institutionalised residential settings (e.g. Social Care Future, 2021)
>
> **Independence**: Community care embodies good principles of prevention – helping to keep people independent and thriving for longer. While residential care is unlikely to never be needed, the trajectory towards more intensive health and care support can be smoothed.
>
> **Outcomes:** Strong community care systems are an established way to boost outcomes – by providing people with more proactive, preventative and tailored health and care services. [As per Edwards, 2014]
>
> **Assets**: Those receiving care in the community are far less likely to experience catastrophic care costs (and guaranteeing they do not is far less expensive for a government aiming to avoid anyone having to sell their home to pay for care).

Despite these prospective benefits, there has been little real success in bringing more care into the community. A community-led model of social care relies on a system that provides care at the earliest possible point, with the ambition of maintaining independence and dignity for as long as possible. But severe funding pressures have left the country with a care system that often only provides care at the latest possible point – once someone's needs have deteriorated and more intensive support, often outside their home, is the only available option.

This is reflected in the international data. The UK has a higher proportion of people in care homes and hospital settings than other, comparable countries (Figure 2).

Figure 2: Location of death, selected European countries against UK

	Home	Hospital	Care home
European average	**33%**	**44%**	**18%**
UK	**23%**	**47%**	**28%**
Difference	**-10%**	**3%**	**10%**

Source: Recreated from Hunter & Orlovic, 2018.

These percentages are likely to rise in the coming years and decades, as a result of a growing and ageing population.

A lack of community care provision is further evidenced by data on unmet need. To give one example, 2019 research showed that 38 per cent of people living with cancer and on a low income could not get the practical support they needed within their home. 34 per cent could not get the practical support they needed to undertake activities outside of the home. In many cases, making better support available for these people – to maintain independence, in their homes - would not have prevented them from *ever* needing residential care [Macmillan, 2019]. But the lack of support almost certainly will have accelerated their trajectory to intensive or residential support - and constitutes a missed opportunity to maximise independence and quality of life.

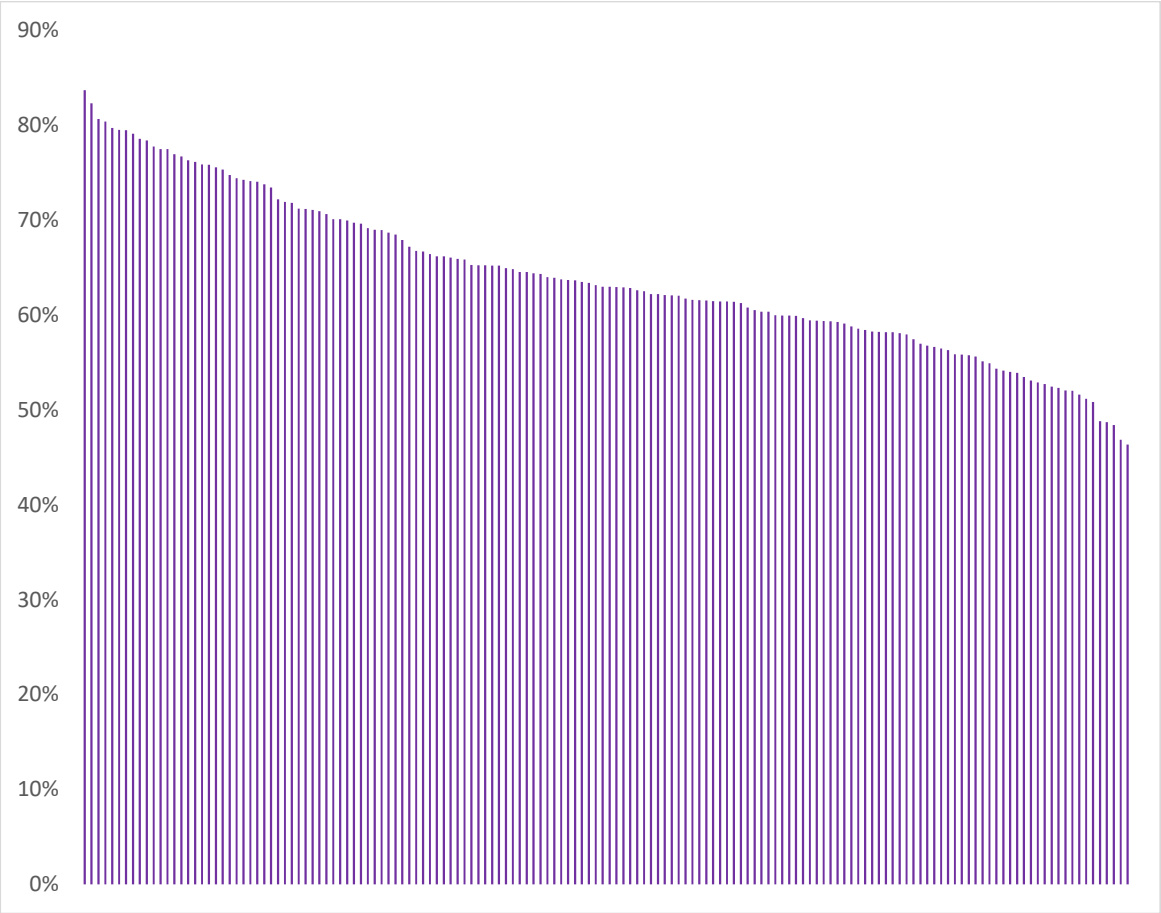
A lack of community care can also underpin a reliance on acute care in hospital settings. People in hospital beds, who don't need to be, are at risk of experiencing 'non-beneficial treatments' (NBT). One 2014 study suggested that 33-38 percent of patients received at least one NBT at the end of their life. This is both bad for quality of life and for public finances.

QUANTIFYING THE OPPORTUNITY

There is an immediate opportunity to address a postcode lottery in access to community-led social care across England. New analysis by healthcare management consultancy and analytics company CF shows that the proportion of care provided at home varies across different councils - from as low as 46 per cent to as high as 84 per cent (looking at those ages 65+ only).

Figure 3: There is large variation in community-care provision across England's local authorities

Analysis of long-term and short-term care for 65+ year olds provided at home by councils with adult social care responsibilities, 2018/19 dataset

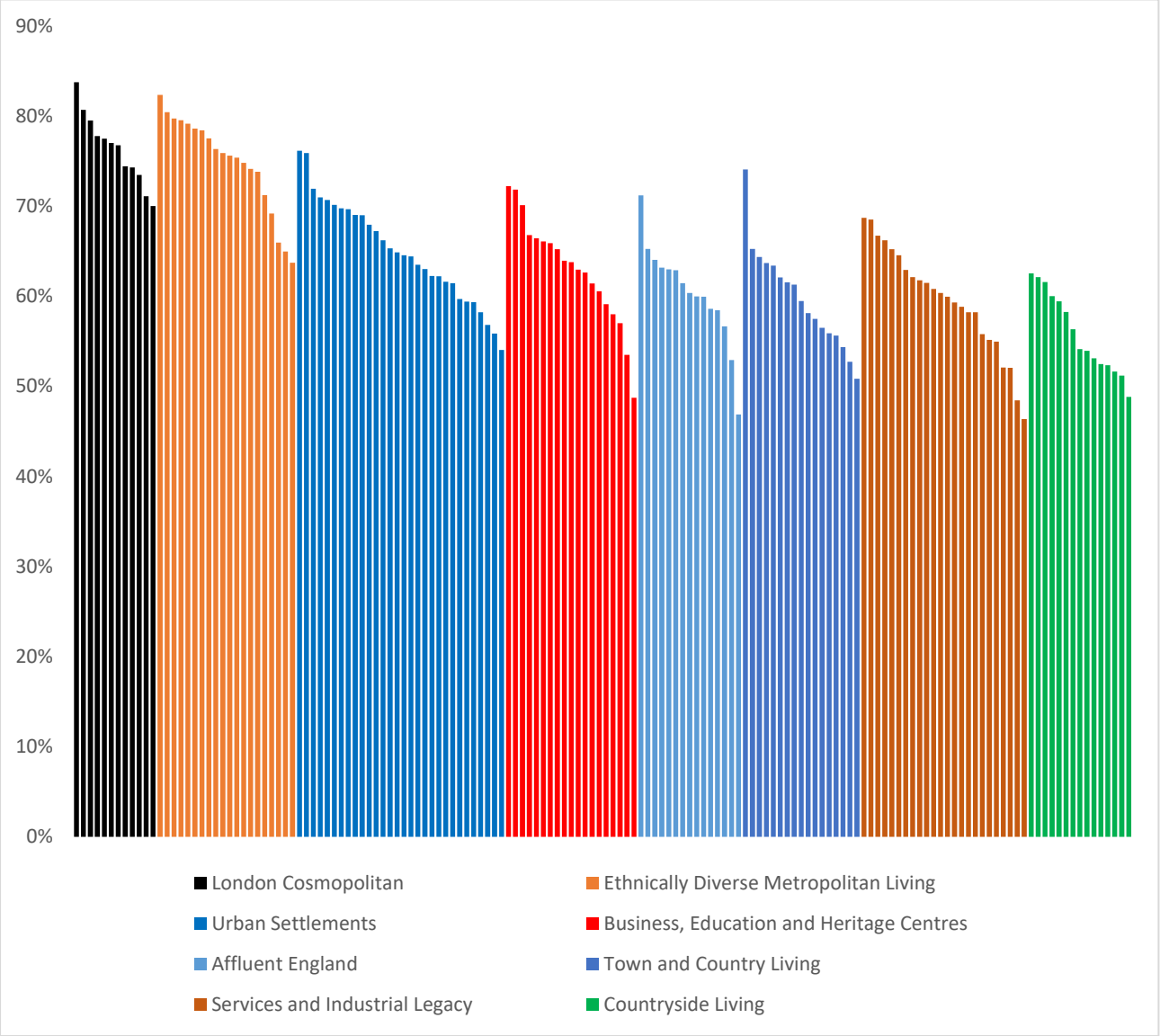


Source: CF Analysis of NHS Digital (2020)

Some of this variation is justifiable – if only because of different local authority demographics. However, we can focus in on 'avoidable variation' by comparing 'like for like' local authorities. The Office for National Statistics produces area classifications for local authorities, which help group them by demographics and geography. CF's analysis shows significant variation in the availability of community-based social care even within these groups of similar authorities.

Figure 4: There is widespread variation in community-care provision among similar local authorities

Analysis of long-term and short-term care for 65+ year olds provided at home by councils with adult social care responsibilities, broken down by ONS area classifications, 2018/19 dataset



Source: CF Analysis of NHS Digital (2020), ONS (2011)

Based on these statistics, we can quantify the possible benefits of a shift towards more community led social care. If every local authority provided care equal to the upper quartile among comparable authorities, 80,000 more individuals over 65 years old would receive care at home - and £1.1 billion of savings could be realised per year from social care budgets. These savings would come from community care being cheaper (Figure 5), and a more preventative way to provide support, and savings could be reinvested in tackling unmet need.

Figure 5: Care in community settings is about a third of the cost of residential or nursing home

Cost of different care option, by time period and episode

	Residential	Nursing	Community
Average length of stay (Weeks)	140.1	108.9	84.1
Total Cost (per episode)	£92,354	£92,202	£24,755
Total cost (per day)	£94.14	£121.00	£42.06

Source: CF Analysis of National Audit for Intermediate Care (2018); PSSRU (2020); Forder and Fernandez (2011); NHS Digital (2019)

80,000 more people in community/home settings, rather than residential and hospital settings, would also mean more people avoid the catastrophic care costs that may force them to sell their home. For example, if avoidable community care variation was reduced alongside the introduction of free personal care, we find the following:

- Catastrophic care costs incurred from domiciliary care would essentially be eliminated (by free personal care)
- Free personal care would reduce the overall number catastrophic care costs would reduce from 143,000 to 80,000 – taking the rate from 1 in 3 care home residents to 1 in 5 care home residents [Independent Age, 2018]
- Reducing unjust variation in community care settings would reduce the care home population by a further 80,000 people
- Meaning that up to an estimated 16,000 people would avoid catastrophic care costs – bringing the total number avoiding catastrophic costs up to around 80,000 people (from the two policies combined). Catastrophic care costs are the leading cause of people selling their home

If the government were to cap care costs, this would mean significant further savings for the state in funding and delivering their ambition that no-one need sell their house to pay for care.

Figure 6: NHS beds could be freed if there was more optimal use of, and capacity in, home care and community settings

Review of literature on hospital bed use where community settings would be more appropriate

Report	Area Covered	Proportion of Patients in Hospital who could be cared for at home	Proportion of bed-days potentially saved by increasing access to home care
Why not home? Why not today? LGA 2018	Bristol, Hampshire, Lancashire, Staffordshire, Northamptonshire, Leeds, Liverpool, Sefton, Nottingham City, Sheffield, Fylde Coast, North Cumbria	31 per cent of MFFD patients (27 per cent bed base)	8.4 per cent
CRESH System Bed Audit 2020	Crawley, East Surrey, Horsham	11 per cent MFFD patients (34 per cent bed base)	3.7 per cent
South West London bed audit 2015	South West London	41 per cent of non-qualified dasys (42 per cent of bed base)	17.2 per cent
Isle of Wight Audit 2019	Isle of Wight	51 per cent of fit-to-leave patients (41 per cent of bed base)	21.3 per cent
Darent Valley Hospital Bed Audit 2019	West Kent	26 per cent of MFFD patients (22 per cent of bed base)	5.7 per cent
Harrogate Health System bed audit 2019	Harrogate	35 per cent of MFFD patients (28 per cent of bed base)	9.8 per cent
Devon Acuity audit 2018	Devon	50 per cent of fit-to-leave patients (23 per cent of bed base)	11.5 per cent
Weighted average by population	11.65 million	32 per cent of fit-to-leave patients (29 per cent bed base)	9.6 per cent

Sources: CF Analysis of LGA (2018); Public Health Devon (2018), Harrogate NHS Trust (2019); Isle of Wight NHS Trust (2019); South West London and Surrey Downs Healthcare Partnership (2016)

Elsewhere, there could be benefits for the NHS, too. A review of the literature shows that between four and 21 per cent of hospital bed-days are occupied by patients who could be provided care at home as an alternative. Based on a weighted average of these studies (9.6 per cent of bed-days being occupied by patients who could be provided care at home), we estimate that the NHS could save £1.6 billion from optimised community care. This means a total prospective saving of just over £2.5

billion – just from addressing the community care postcode lottery – which could be invested in better health and care services.

LEVELLING-UP COMMUNITY CARE

There has been a real terms cut in social care funding since 2010-11. Even then, this national trend obscures significant regional variation. For example, public social care expenditure has reduced by more than 12 per cent in the North East over the last decade. By contrast, social care expenditure has risen in the South East, South West and East of England regions [Clugston, 2021].

Despite these funding pressures, there is often greater new demand for care in Northern regions. As Figure 5 shows, 1.93 million new requests for support in England, 671,000 came in the North East, North West and Yorkshire and the Humber (35 per cent). This is disproportionate to the region's 27.6 per cent of the country's population.

Figure 7: The North of England faces disproportionate demand for extra social care support across settings

New requests for care by region, 2019-20, by broad English regions

Region	New Requests for Support (Total)	New Requests for Support (%)	% of England Population
All Ages			
North of England	671,000	35	27.6
Midlands	576,290	30	30.2
South of England	683,250	35	42.3
England	1.93 million	100	100[1]
Over 65s			
North of England	452,000	33	27.6
Midlands	426,000	31	30.2
South of England	492,000	36	42.3
England Average	1.37 million	100	100

Source: Author's analysis of NHS Digital (2021); ONS (2021a)

A lack of community care capacity often leads to a reliance on overly intensive, acute-led care models of care. For example, analysis by a team from Imperial, the

[1] Columns may not sum exactly due to rounding

University of Edinburgh, Universitè de Lausanne and IPPR found some regions had significantly more expensive and intensive care in their final year of life:

Figure 8: Social Care Cuts align to most Intensive Acute-Led Care Models for People in Final Year of Life

Level of acuity, and average cost per person, of end of life care in England

	Rank, Most Acute-Led Care	Rank, Most Expensive Care, Last Year of Life	Total Cost, Average per Person, Last Year of Life (£)
North East	3	3=	7,888
North West	5	3=	7,888
Yorkshire and the Humber	4	2	8,192
West Midlands	2	5	7,445
East of England	6	6	7,342
South West	9	8	6,692
South Central	8	9	7,051
London	1	1	8,276
South East Coast	7	7	7,329

Source: Thomas (2021)

This is sub-optimal for patients. And it is expensive, meaning less money to invest in other healthcare services within these places.

A combination of rising demand (unequally distributed around the country); austerity-impacted local budgets; and unequal capacity of people to (even partially) self-fund their care is likely to lead to less preventative, community interventions taking place. That is, strained local authorities are likely to reserve care for those with the most severe needs – and to miss opportunities to provide those with less severe needs the support they need, in their home and community, to maintain independence for longer. The above indicates this is far more likely to take place in the North than the South – where funding cuts have been higher, there are more chronic health needs, and the impact of austerity has been more severe.

The 'logic' of austerity was that funding pressures would force local teams to use cheaper, community services. In fact, it has just embedded a broken model, based on reaction rather than prevention – all the while allowing unmet need to rise to record levels.

Ensuring these places have the resource, capacity and expertise needed to deliver greater home and community care could contribute to the 'levelling-up' in several ways. Firstly, it would mean those most at risk of losing all the full value of their assets – i.e., working people with lower value homes, often in the North of England – would be better protected from catastrophic costs. Second, it would mean places with unsustainable acute-led care models are more resilient in the face of a future of

rising demand. The status-quo alternative is an almost certain spike in already high levels of unmet need through the next decade and beyond.

PERSONALISING COMMUNITY CARE

A shift to community care should be an opportunity to focus on outcomes, rather than activity. This would mean commissioning significantly more diverse, relational and personalised social care services – to replace the mechanical and institutional 'life and limb' services that are currently the norm.

The worst example of sub-optimal, activity-focused social care in the community setting is the 15-minute 'flying visit'. Appointments of this length are still commissioned in around a quarter of England's councils [Albert, 2017]. Inevitably, these appointments are focused on getting through a mechanical list of tasks as quickly as possible, with some documentation of social care workers being timed for each task. It is dehumanising, unpopular – and has a negative impact on important social care indicators like quality of life, loneliness and isolation.

This is not inevitable. Models of care do exist that provide people more choices - or which better tailor care to the needs and demands of a specific diagnosis, like dementia. The below case studies outline models that are not used as widely as they could be in this country, but which highlight opportunities for greater personalisation and choice within community care. Each has been selected on the basis of not just being better quality, but also because they give more attention to how social care can enable a good life (rather than just manage people). In some cases, they could be delivered within existing budgets.

Case study 1: Shared lives schemes

There are 150 shared lives schemes in the UK. Shared Lives provide opportunities for adults to live, independently, in their community – with the support of a community network. Within the schemes, Shared Lives carers use their own home and family life, to share it with someone who needs support. Carers earn up to £32,500 per year – and receive training, breaks and a support network. It provides a community-based and relationship focused alternative to residential care.

Evaluations of shared living schemes have been positive. Over 96 per cent of Shared Lives schemes are rated good or outstanding across England, compared to just 65 per cent of large independent nursing homes and 72 per cent of large independent care homes [Care Quality Commission, 2018]. In 2018, an independent review found that Shared Lives can provide a preferable model of respite services for older people and people living with dementia. Moreover, estimates suggest that Shared Lives could offer £225 million of savings per year, if every area caught up to the best performing – thanks to reductions in A&E and hospital admissions.

In other cases, where residential care is needed (and this briefing is not an argument that we will not need residential care in the future), there are models based on far more tailored, personalised experiences. For example, the sharp rise in

dementia rates over the last few decades has presented a challenge to status quo health and care models in the UK. International examples show better practice can be designed and delivered, at no extra cost than standard residential care.

Case study 2: Buurtzorg

Buurtzorg translates to 'neighbourhood care' and is an innovative homecare model developed in the Netherlands. It is a system designed to allow people with care needs to live independently, with less dependence on formal support.

The model runs as follows. A district nurse provides coaching for the individual and their family, to build their capacity and confidence to deliver care. The focus is on relationships, with nurses encouraged to spend the vast majority of their time with people.

Evaluations have suggested the scheme comes with significant benefits. The cost per hour is more expensive. However, it is much higher quality and orientated towards prevention, meaning only half as much care as is needed on average. People live better, more independent lives – in the place they call home, and with people they know – for 40 per cent less cost than traditional homecare models.

Case study 3: The Equal Care Platform Cooperative

People receiving care in West Yorkshire's Calder Valley might receive their care from Equal Care Co-Op. It's a registered, multi-stakeholder co-operative – delivering a digital care support platform that, in its words, puts 'power in the hands of those who matter most – the people who give and receive support'.

There is much that is innovative about Equal Care as a model. It is a Platform Co-Op, meaning it uses a digital platform to provide its service. Their collaborative platform allows each person to choose their relationships, and then decide where and how their support takes place. It is funded by the community, rather than by private equity, through the community shares model – a model that allows investment in enterprises that benefit a community, investors to then have a democratic say, and which have proven themselves a remarkably successful form of capital since 2009. And it is multi-stakeholder in design, which means it is governed in dialogue – in this case, with both the givers and receivers of care in focus.

There are emerging services, with evaluations pending. But the early indications are very strong. Testimony from people suggests a sense of ownership and empowerment, not always associated with social care. Ambitions include a target to pay new care workers £20,000 per year at the very least – a full 25 per cent above the average in the industry [Borkin, 2019].

There are three advantages in Equal Care's model. First, it's innovative platform allows it to make significant efficiencies. Second, it's democratic ownership model allows those efficiencies to be invested in people and workers. Finally, its platform is designed around empowering those members, care recipients and providers alike –

helping address problems with power dynamics that often plague other provider models.

POLICY RECOMMENDATIONS

Delivering Community First Social Care requires a strategy to fund community infrastructure, spread innovation, make outcome-based commissioning the norm and investing in the workforce. We outline four evidence-led recommendations to government, below.

Recommendation 1: Introduce a right to care in a place we call home through stronger advocacy and £5 billion investment in infrastructure and innovation

The Social Care Act in 2014 set out local authorities' duties in relation to providing publicly funded care and support. This included duties to carry out an assessment of anyone who needs care and support; involvement of the person and carers in care planning; an access to an independent advocate to support the person's ability to enact their preferences through care planning. However, as deliberative research continues to show, it has not done enough to genuinely personalise care.

One of the key challenges is a continued lack of access to care in places people call home. As this paper shows, there are likely many thousands of people receiving care in institutional, residential or acute settings who would benefit from care in a community or home setting. Moreover, there are many within residential and acute settings who could have had their independence maintained if earlier, home-based social care support had been available.

As such, we recommend the government take the opportunity to place a new statutory duty on local authorities to provide people care in a 'place they call home'. This should not mean providing care at home in absolutely all circumstances, regardless of whether clinically appropriate. Rather, it should mean instilling a right to state a preference for care at home – as well as greater stipulations on care in residential settings being highly personalised and high quality when they are needed.

Practical steps towards delivering this could include:

> Data and accountability: The centre should work with local authorities to agree and set targets on providing a certain proportion of care in the community based on local authorities with similar social, economic, and demographic contexts.
>
> Increased independent advocacy: Carers who do not believe their right to care in the place they call home should have the means to secure independent advocacy. Local authorities currently have a duty to arrange independent advocates when people have 'substantial difficulty' in being involved in their care and support assessments – and not receiving care in a

suitable place should be considered above that threshold. [DHSC et al, undated]

A central complaints process: Where an individual, advocate or carer feels a right to care in a place they call home is not being met, there should be a centralised complaints procedure. In the first instance, this could be facilitated by a specialist care-at-home unit within the Local Government Ombudsmen.

This would be in line with wider moves across health and care towards shared decision making, where care isn't done to people, but rather there are meaningful ways in which they can action the power of their voice and preferences.

A right to community first social care cannot be delivered without upfront investment in the right infrastructure. In the US, Joe Biden's commitment to home and community-based services has attracted public investment of $400 billion over eight years, as part of his c.$2 trillion stimulus. This investment has been justified on the basis of creating future-proof jobs, across the whole country – something that, in the UK, would be compatible with the government's 'levelling-up' ambitions. The equivalent investment in the UK would cost approximately £5 billion per year, for the next eight years [Jung et al, 2021].

This level of investment is almost exactly equal to the cost savings our analysis suggests could be achieved through a combination of free personal care, and more community-led care. Optimising the amount of care provided in community settings would come with cost savings of £2.5 billion to the NHS and local authorities. The remaining £2.5 billion could be saved by scrapping the NHS Continuing Healthcare scheme, which would be redundant if free personal care was introduced [Quilter-Pinner & Hochlaf, 2019].

In reality, savings and investment will not perfectly align. The savings possible from better care would be achieved in the long-term and rely on upfront investment. As such, we recommend a period of investment in transformation, designed to realise a higher-quality and more-efficient system by the end of the decade.

Following the lead of President Biden in America, we recommend £5 billion investment – split between two funding priorities. As recommended by IPPR previously, £2 billion should be spent on increasing community care capacity. This is important to achieving the aspirations laid out above. As argued by IPPR previously, care in the community relies on providing the infrastructure, rapid support services and capacity needed to maintain independence. That is, the government cannot simply move people into community care settings without resource and capacity, and still expect a more sustainable and high quality care system.

Investment in the following would help facilitate more community social care:

- Increasing commissioning budgets, to facilitate a wider move to outcome-based commissioning

- Increasing the number of packages available in community settings, to pre-empt increased demand
- Optimising social care rates, to support quality, sustainable care packages
- Increasing community infrastructure, including rapid response teams, district nursing numbers and support for carers like 24-hour telephone support lines
- Expanding community support packages to those currently experiencing unmet need

Second, the government should introduce a new 'community development fund' – to help facilitate a shift to the kinds of best practice models outlined by the case studies in this briefing paper. National support for independent living has been lacking since the Independent Living Fund was closed in 2015, and this could be considered a reprioritisation of independence as an explicit goal of social care.

Spreading and scaling innovation needs initial investment for three reasons. In some cases, new types of support will come with an upfront cost. Second, there are areas where state support could help scale the models of care outlined in this paper. Providing seed-funding, match-funding or pump-prime funding are all ways the state can invest in innovative models, that are otherwise struggling to get a foothold. Perhaps most importantly, funding may be needed to enable 'double running' of services – where local authorities transition to more community-led or more extensive options for provision.

In 2020, IPPR recommended a transformation fund to help spread innovation in the National Health Service [Thomas et al, 2020]. Our logic was a small, time-limited investment in innovation would have a large long-term return on investment. This paper indicates the same would be possible in social care. We recommend this is introduced with an average fund value of £2.5 billion per year – and run for eight years. Funding should be skewed towards early years, and slowly tapered off thereafter.

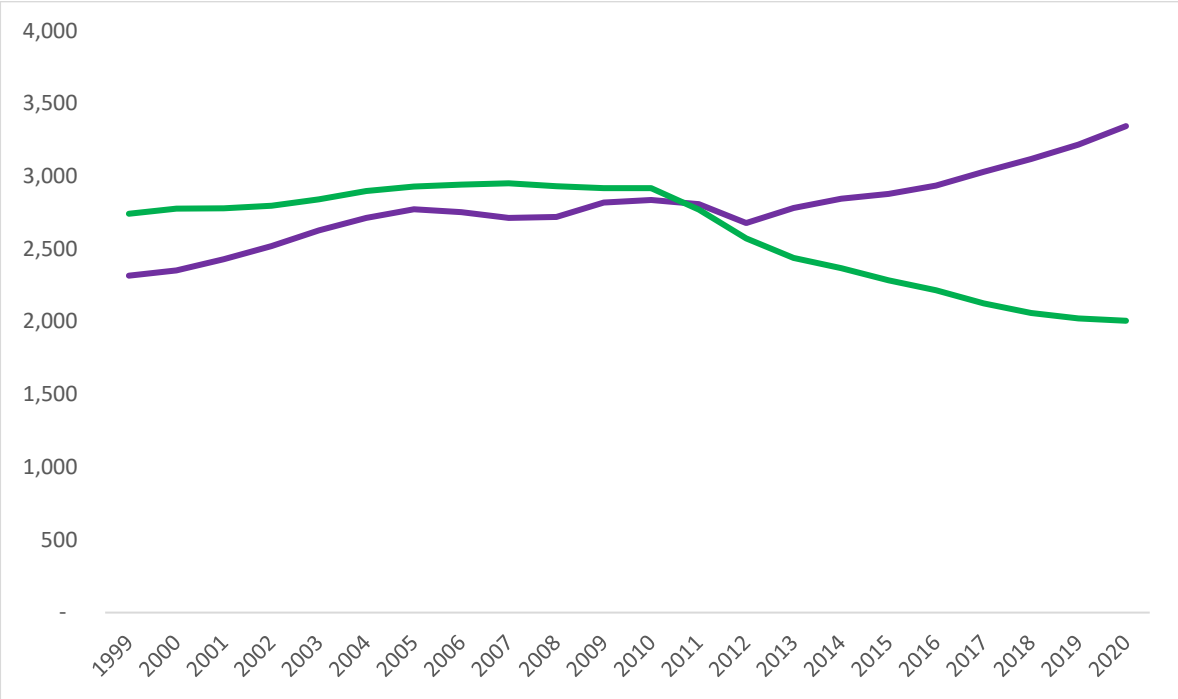
Recommendation 2: Rebuild genuine commissioning expertise in local authorities

IPPR research has previously indicated that commissioning capacity and expertise has been significantly reduced in local authority, because of staffing cuts during austerity. A lack of commissioning expertise means two barriers to quality social care. Firstly, it makes it difficult for local authorities to commission on outcomes – which requires specialist skills – and so more likely to commission on simpler measures like cost and activity. Second, it makes long standing relationships with innovative care providers hard to develop – likely leading to a preference for large providers, with capacity to actively promote their care services.

In the face of the complexity of each local care market – and given the importance of picking the right provider, with the right standards, approach and ownership model – we recommend that commissioning expertise is rebuilt within local authorities. This need not constitute a massive increase in employment of public sector officials. For example, it could be achieved through a recalibration of the shift of expertise from local to national government since 2010.

Figure 9: The public sector workforce has been centralised in the last decade

Local (Green) and National (Purple) Public Sector Employment in Millions, 1999-2020.



Source: Recreated from Johns (2020), ONS (2021b)

This increase in commissioning capacity should be combined with a sustained effort to develop the right kind of commissioner. Evidence from Wigan found that changing how social care worked relied on the right kind of mindset and attitude among local employees, on the principle that 'how we do things is just as important as what we do'. The King's Fund evaluation of the Wigan Deal highlights fostering the right attitudes as the priority in scaling the Wigan Deal. Key behaviours include:

1. Optimism: An attitude that better is possible, and willingness to build the collaborations and relationships needed to achieve it
2. Bravery: A shift from focusing on managing people and risk, to a focus on innovation and avoiding 'missed opportunities'
3. Accountability: Individuals who were directly responsible for making things better [SCIE, 2018]
4. Co-creation: A commitment to working with people using services, as equals. In social care, one example of best practice are Community Circles, where people using support are asked to outline their priorities to commissioners directly (Think Local Act Personal, 2019).

Working with pioneers in Wigan, with national bodies like Skills for Care and the Social Care Institute for Excellence, the government should develop and deliver a national commissioning academy for social care. This should have two roles: firstly, working directly with local government to ensure the right behaviours are

incentivised, rewarded and developed among their workforce; secondly, providing direct training to commissioners in developing their approach.

Recommendation 3: Introduce new commissioning standards that all providers must adhere to in order to drive improvements

At present, a lack of commissioning expertise can sometimes see local government retreat behind complicated commissioning specifications – which often have no bearing in what people want or need, and which themselves prioritise short-term cost savings and 'activity' over outcomes.

As recommended by IPPR previously, the government should change this by setting a new, binding commissioning charter for social care– a set of standards that support outcome-driven commissioning decisions [Quilter-Pinner, 2020].

This should include:

- A commitment to high quality care: Contracts should only be awarded where there is confidence in quality and where there is a clear accountability mechanism between providers, social care workers, carers and people using support.
- Workforce standards: Contracts should only be awarded where organisations pay a real living wage, provide adequate training and support, and engage in sectoral bargaining
- Economy: Preference should be given to local organisations, that can demonstrate value to their local economy
- Environment: Preference should be given to organisations that can evidence high environmental standards

This would be in addition to other requirements around financial sustainability and stability, explored in more detail in recommendation 2.

Based on the findings set out in this paper, we suggest two additions. Firstly, the ethical commissioning standard should take account of the promise of innovative, democratic ownership models in recalibrating power relationships within social care. As such, there should be a preference for care provided by co-operatives, social enterprises, and other innovative, community-embedded care providers.[2] This preference exists in legislation in Wales, where the 2014 Social Services and Well-being Act set out a legal framework for transforming social services - including a duty to promote social enterprises and co-operatives which involve people who need care and support'.

Secondly, there should be focus on care that is co-created with people, rather than imposed on them. Providers should be required to put in place meaningful consultation with three key stakeholder groups: care recipients, carers and workers. Their ability to action these insights should be considered integral to any assessment

[2] With local leaders and commissioners empowered to develop, select, incubate and grow these kinds of providers autonomously, and in line with their 'market shaping' role in the Care Act.

of their quality, as measured by a) overall satisfaction of people using their services and b) the number and type of complaint received about their provision.

Recommendation 4: An empowered social care workforce

An on-going crisis in the social care workforce limits the potential for more empowering, less institutional and more community-led care. As of October 2020, Skills for Care data shows:

- 112,000 vacancies in England
- A turnover rate of 30.4 per cent in 2019/20 (430,000 leavers)
- 24 per cent of jobs are zero-hour contracts
- Median pay of £8.50 [All Skills for Care, 2020]

This is a poor foundation for high quality care, and actively supports a system driven by activity and treating care as a mechanistic task. If we are committed to a model of care that addresses unmet need, maintains independence and helps reach our potential, then we need a social care workforce model that is conductive to that aim.

To help achieve that, and consistent with other IPPR reports, we recommend formalising better conditions, training and progression for all social care workforce. As a first step, this should include:

- Minimum pay standards for social care workers
- Significant investment in training, and opportunities to progress into service design roles
- Formalisation of the profession and collective bargaining through a social care professional body, equivalent to the larger royal colleges.

Another key enabler of community led care is empowering carers. In lieu of a government solution on social care, the strain of rising demand for care services has fallen on carers. Since the 2011 census, the number providing over 50 hours of care a week has tripled. Worse, during the pandemic, 72 per cent went without a break and 3 in 4 were exhausted as of June 2021.

What about funding reform?

Of the options being considered by the government, we suggest free personal care has the most merit. There is much to recommend the policy. Importantly, it is popular. In 2020, our polling showed:

- 61 per cent of people believe funding for social care has been below what is needed (25 per cent say it is about right or more than needed)
- Over half believe social care funding should increase once the pandemic ends (6 per cent believe it should decrease)
- The most popular funding option for a new social care settlement is general taxation (39 per cent – no other option has more than 20 per cent support)

Crucially, attitudes to reform within our polling were very similar between both Conservative and Labour voters – suggesting cross-party consensus.

Second, it has cross-party support. Free Personal Care brings together politicians with markedly different beliefs and values. In 2019, Jacob Rees-Mogg MP argued for free personal care on the basis of fairness: free care, at the point of need, should not depend on whether you're diagnosed with cancer or dementia [see Lightfoot et al, 2019). In 2021, Labour Mayor of Manchester Andy Burnham described free personal care as the 'only option'.

Beyond its wide base of support, it has more practical merits. While free personal care is not cheap, it is not significantly more expensive than the other options out there. In the year 2030, for example, free personal social care would cost just £2 billion more than the floor and cap policy recommended by Theresa May in the 2017 Conservative party manifesto. Furthermore, polling shows that three in four people in the general public would be happy to support it through general taxation. Estimates suggest free personal care could be delivered through either a 1.31 percentage point increase in national insurance or a 2.11 percentage point increase in income tax [Independent Age, 2019]

However, this paper recognises that no funding solution will transform social care entirely. Social care, as a sector, has the potential to be empowering for the people who use it, to offer choice and personalisation and to prevent need and ease strain on the NHS. And it is based placed to achieve all these aims if its support is based – first and foremost – on providing early intervention, within the community, in an attempt to ensure people can live good, independent and flourishing lives for as long as possible.

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APPENDICES

Evaluation of social care funding reform options

	Quality and Integration	Unmet Need	Personalisation	Catastrophic Care Costs
Extra Funding	No change	Potential change, though may be hampered by problems with status quo system	No change	No change
Cap and Floor	No change	No change	No change	Depending on levels for the cap and floor, care costs would be significantly reduced or eliminated
Integrated Budget	Significant alignment of NHS and social care	Potential change, if merged budgets incentivise greater focus on social care and prevention	No change	No change
Free Personal Care	Significant alignment to NHS model (free at the point of delivery)	Significant scope to meet unmet need, if well implemented	No change (if implemented as in Scotland)	Catastrophic care costs reduced by up to 40 per cent
Hypothecated Tax	Hypothecated tax is not widely used elsewhere, meaning a bigger difference in our NHS and social care system	Depends how funding is used, but not implicit	Depends how funding is used, but not implicit	Depends how funding is used, but not implicit

Source: Author's analysis

Free personal care and the community shift: a golden combination

	Quality and Integration	Unmet Need	Personalisation	Catastrophic Care Costs
Free Personal Care	Significant alignment to NHS model (free at the point of delivery)	Significant scope to meet unmet need, if well implemented	No change (if implemented as in Scotland)	Catastrophic care costs reduced 60,000
Community Shift	Significantly helps NHS/social care work together (e.g. community capacity supports discharge), and aligns social care to long-term NHS aspiration of more community-level care.	Prepares social care system for future demand; supports levelling-up; helps generate unmet need created by funding cuts over last decade	Community care already more in line with people's preferences; provides an opportunity to personalise further, by capitalising on innovation	Catastrophic care costs reduced by up to a further 16,000 (assuming free personal care in place)

Source: Authors Analysis

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