Institute for Public Policy Research

ETHICAL CARE

A BOLD REFORM AGENDA FOR ADULT SOCIAL CARE

Harry Quilter-Pinner

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SUMMARY

With the possibility of a long-term funding settlement for social care, there is an urgent need for a bold reform agenda. For two decades, politicians have promiseda long-term funding settlement for social care but failed to deliver on this. As a result, the policy conversation has been unable to move beyond the need for more funding. But we are now moving closer towards a solution, with a growing cross-party consensus behind the idea of introducing free personal care as recommended by IPPR's Lord Darzi Review. If this happens, social care will need a bold vision and reform plan to ensure this investment fundamentally transforms the care.

Enabling people to live fulfilling and meaningful lives as they grow older must be at the heart of our vision for social care. The traditional view of social care is quite limited, covering basic tasks such as help getting up, washed and dressed; eating meals and shopping; and taking medication. However, in the context of a growing gap between life expectancy and healthy life expectancy, we must broaden this vision to include improving people's wellbeing as they age, and therefore activities designed to engender purpose, meaning and social connection.

There are many examples of innovative and high-quality care across England, but there is also significant variation. Based on our qualitative research and a literature review, we define high-quality social care as care that is: accessible, personal, relational, preventative, joined-up, and safe. There are some excellent examples of this across the country including Shared Lives, local area coordination, Buurtzorg, and NHS England's enhanced health in care homes vanguard (to name just a few). But too many care providers are failing to learn from the best. There is a significant postcode lottery in care that must be addressed to deliver high-quality care for all.

Our research has identified three major drivers of quality in social care.

- **Funding:** Cuts to adult social care spending have significantly reduced access to care. This is a national scandal, but it has helped to protect quality for those who are still receiving it. However, we may now be reaching a 'tipping point', where the drivers of quality are overcome by budgetary pressures. Moreover, cuts to non-statutory services may have contributed to low levels of user satisfaction in terms of 'social connection'.
- **Workforce:** There is a strong consensus in the sector that workforce is a significant driver of quality. In particular, the Care Quality Commission (CQC) has identified a link between high vacancy and turnover rates, and poorer levels of care being provided, while carers themselves highlight a lack of time and training as a factor. This is concerning because we are facing a workforce crisis, with high turnover and vacancy rates driven by low pay, training, progression and status in caring jobs.
- **Provider type:** There is some evidence that the provider type and a provider's business model has an impact on quality. Future Care Capital analysis of CQC data shows that, on average, private residential care providers deliver a lower quality of care than is delivered by the voluntary and state sector. This can be explained in a number of ways; for example, there is evidence that private providers have worse workforce outcomes, are more unstable (with a higher risk of bankruptcy) and tend to be larger (with smaller care homes on average delivering better care).

Based on our research, we call for a package of interventions across each of these three areas, which include the following.

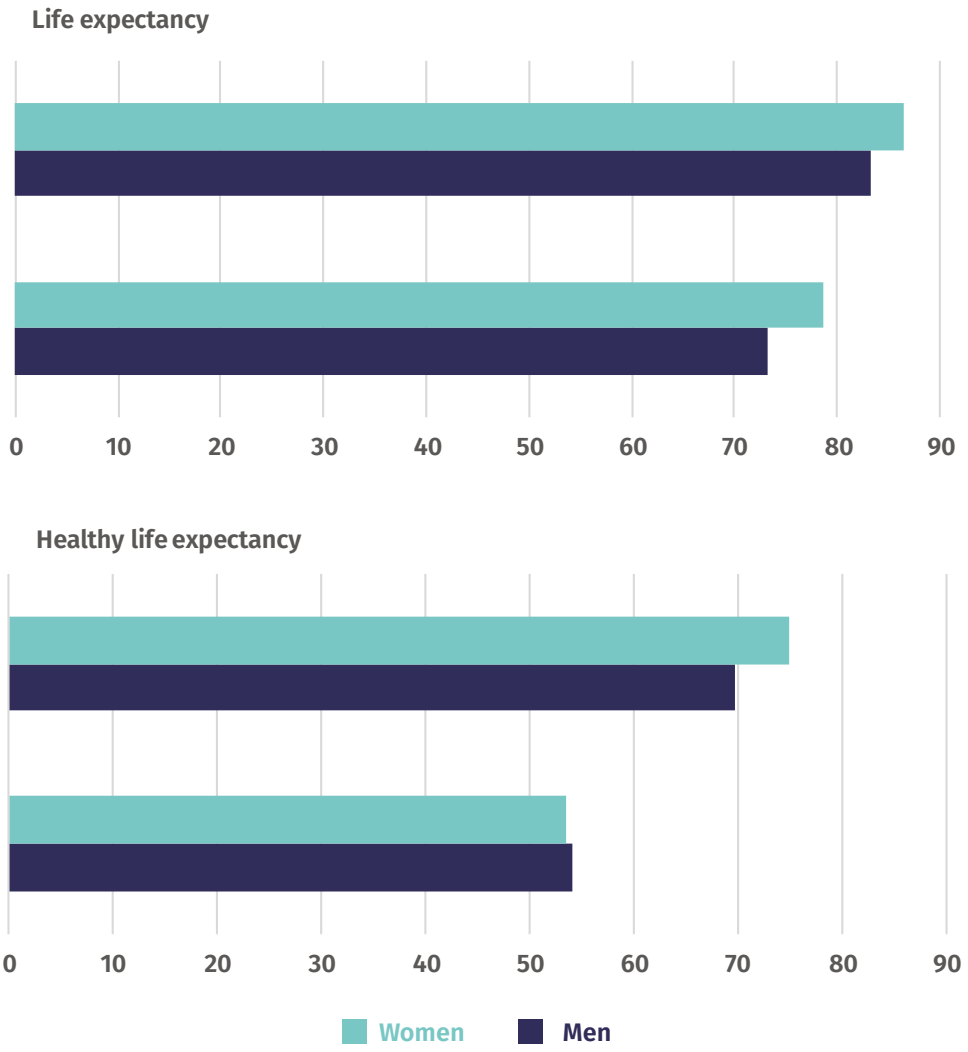
- **A long-term funding settlement for social care to ensure the system is well-funded.** Government should commit to providing the additional funding – up to £20 billion per year by 2030 – needed to introduce free personal care. This should be funded out of increases in general taxation (either national insurance or income tax). £2 billion of this new settlement (over a five-year period) should be top-sliced to create a new social care transformation fund with an objective of spreading best-practice across the system.
- **A 'new deal' for the social care workforce to ensure social care staff are well-trained, well-paid and well-respected.** All social care providers receiving state funding should be required to pay at least the real living wage at a cost of £740 million per year. A new system of sectoral collective bargaining for adult social care should be introduced to drive up working conditions in the sector. And, to improve professionalisation in the sector, the care certificate should become a robust and mandatory licence to practise for all care workers.
- **A new ethical commissioning charter to drive low quality and unethical providers out of the market.** Government should introduce a new ethical commissioning charter – with conditions relating to the workforce, care quality and provider transparency – in order to drive a change in the provider market. This would force failing providers out of the market and encourage the entrance or expansion of more innovative, socially-minded providers. To facilitate this, we call for a new Ethical Provider Fund worth £7.5 billion over the next decade to enable the creation of innovative new state or voluntary care providers.

1. INTRODUCTION

Social care is the ultimate 'Cinderella service'. Over two decades there have been two independent commissions, five white and green papers, and two (formal) attempts at gaining a cross-party consensus in order to secure a long-term funding settlement for social care. None have been successful. In the words of Charles Clarke, social care has been put into the 'too difficult box' (Clarke 2014).

FIGURE 1.1: THERE IS A SIGNIFICANT GAP BETWEEN LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY IN THE UK

Comparison of UK life expectancy and heathy life expectancy in local authorities (2015–2017)



Source: ONS 2018

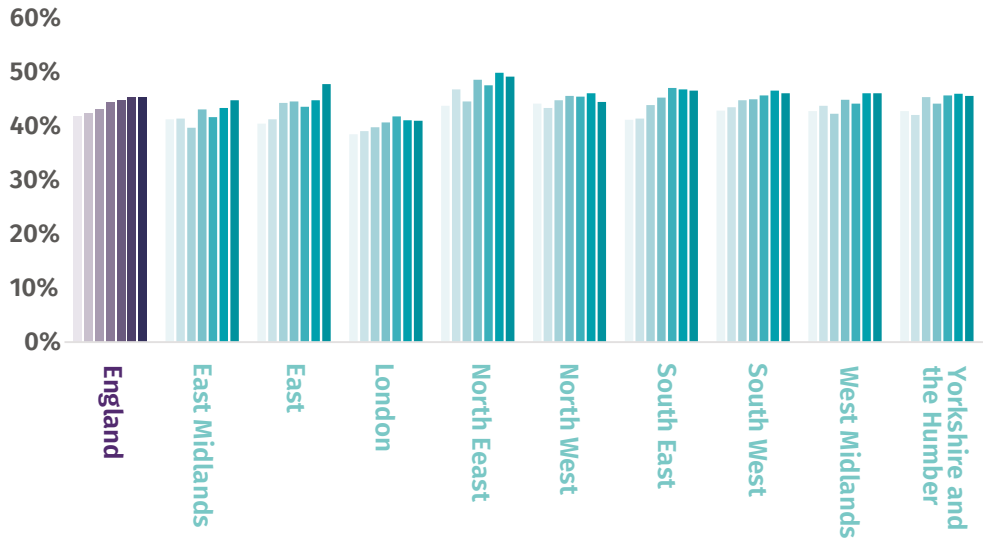
As a result, it has faced a near-permanent crisis. While resources have become increasingly constrained, demand for social care has been rising. This is because healthy life expectancy and disability-free life expectancy have both failed to grow at the same pace as overall life expectancy (ONS 2018), with many more people having to live with multiple long-term conditions or frailty as they age.

Four elements of the social care 'crisis' are worth highlighting in particular:

- **Unmet need:** Since 2008/09, there has been a staggering 5 per cent drop in the number of people receiving publicly-funded social care per year, totalling around 600,000 people (Darzi 2018). This has occurred despite a significant increase in the number of elderly people in need of care. It has left more people self-funding their care, more people reliant on informal care for support, and more people going without care altogether. There are 1.4 million people aged 65+ who face unmet social care needs – over double the number in 2010 (Age UK 2018). Moreover, the gap between need and provision is greatest for those on lowest incomes (Health Foundation 2017).
- **Strains on quality:** Quality across most dimensions of social care appears to have held up surprisingly well (CQC 2017). However, this is from a low base in too many places: more than one in five care providers – looking after over 200,000 people – are currently failing to meet the CQC's quality and safety standards. This grows to one in three when we consider nursing homes (ibid). There is now evidence that social care is at a 'tipping point' where the drivers of improvement will come up short against the pressures on the system (ibid). Finally, there is evidence certain elements of quality – most notably social connection – have been neglected (see figure 1.2).

FIGURE 1.2: LESS THAN HALF THE PEOPLE WHO USED SOCIAL CARE FEEL THAT THEY HAD AS MUCH SOCIAL CONNECTION AS THEY WOULD LIKE

Proportion of people who reported that they had as much social contact as they would like when using social care services, 2017



Source: Darzi 2018; analysis of ASCOF 2018

- **Precarious provision:** Another concerning trend is the growing number of social care providers in the sector in debt or at risk of closure. Two-thirds of councils report that they have had a care provider that has closed, ceased trading or 'handed back' contracts in their area within the last six months (ADASS 2019). This problem has occurred because local authorities have

responded to the cuts in their own budgets by reducing the fee paid to social care providers. This has meant that, in many cases, the fees paid by councils for delivering care have failed to keep pace with increases in the cost of doing so.

- **Workforce pressures:** The impact of the cuts to social care are felt particularly strongly among the workforce. Nearly half the staff in the sector are paid below the living wage – with large numbers also paid below the minimum wage (Dromey and Hochlaf 2018). Partly as a result of this, staff retention is poor and turnover is high, with around one-third of the workforce leaving in any one year. This is leading to significant unfilled staffing gaps, which due to grow from 78,000 today to 350,000 by 2028 – or 400,000 if freedom of movement comes to an end (ibid). This is important because the evidence is clear that the workforce is a key determinant of safety and quality (ibid).

In this context, it is understandable that the policy conversation has been unable to move beyond the need for a funding solution. The focus among policymakers and service leaders has been on simply trying to maintain the existing system, rather than setting out an ambitious reform agenda for the future. But, to win the case for more funding among both the public and central government, social care needs a clear vision of the value it can add to society and the reform agenda that is needed in order to realise this.

There is now, once again, the prospect of a long-term funding deal for social care with Boris Johnson, the prime minister at the time of writing, promising on the steps of Downing Street that: "we will fix this crisis in social care once and for all … to give every older person dignity and security in older age" (Johnson 2019). Meanwhile, the Labour party have backed IPPR's recent proposals for the introduction of free personal care in England (see box) requiring up to £8 billion per year in additional investment (Triggle 2019).

WHAT IS FREE PERSONAL CARE?

The concept of free personal and nursing care derives from the Royal Commission on Long-Term Care for the Elderly, which reported in 1999 (Sutherland 1999). This commission recommended that care – whether it is delivered in the NHS, a care home or in someone's house – should be free at the point of need. The commission distinguished these care costs from the other costs faced by individuals, notably accommodation (or hotel) costs. These would still need to be funded by the individual, unless they met the means test set by the state (have low levels of income or wealth).

This change, in effect, redraws the boundary of the NHS – or at least extends the principles underpinning it – to include elements of social care. The justification for this change rests on the similarities between care in the NHS and social care. It also recognises the interdependency of both systems: only by removing the divide in entitlements between health and social care can you really join-up provision and shift care into the community in order to improve outcomes and efficiency.

This makes a bold reform agenda for social care all the more urgent. Securing agreement for a funding deal from both government and the public may depend on a compelling vision of how that funding would be spent. Furthermore, such a funding deal would be a once-in-a-generation opportunity to fundamentally transform care. Simply putting this funding into the existing unreformed system would be a wasted opportunity. This paper sets out to establish what such a transformation would look like and how it can be achieved.

2.
DEFINING HIGH-QUALITY CARE

WHAT IS SOCIAL CARE?

Social care can be defined as support for people with physical disabilities, learning difficulties or mental illness in order to maintain interdependence and dignity. The traditional view of social care is quite limited, covering basic tasks such as help getting up, getting washed and dressed, eating meals and shopping, and taking medication. However, it is increasingly being broadened to include helping people to achieve wellbeing, including activities designed to engender purpose, meaning and social connection.

This is the definition adopted by the 2014 Care Act, which sets out the objectives and deliverables that local authorities (who are responsible for care) must meet. It states that:

> ***"The general duty of a local authority … is to promote that individual's wellbeing."***
> The Care Act (2014)

'Wellbeing' is defined as:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional well-being
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided)
- participation in work, education, training or recreation
- social and economic well-being
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society.

Given the scale of the life expectancy challenge, there seems little doubt that we must embrace this broader definition of social care. Our social care system must aim higher than simply maintaining basic functioning for people as they age, and instead embrace a much bigger vision of what it means to age well in the 21st century. Failure to do this will result in worse outcomes for older people, additional cost for the state, and lower national prosperity.

DEFINING 'QUALITY' IN SOCIAL CARE

There are a number of well-known quality frameworks for social care, including the CQC's 'five key lines of enquiry' (CQC 2017) (see figure 2.1) which shape how the sector is currently regulated, and Think Local Act Personal's 'I and We statements', which set out a broader vision for the sector (TLAP 2018a). Our definition of quality builds on both of these, as well as original qualitative research with social care leaders, in order to set out a vision for what high-quality social care for all looks like in the 21st century.

FIGURE 2.1: CQC'S FIVE KEY LINES OF ENQUIRY

Are they safe?	**Safe:** you are protected from abuse and avoidable harm.
Are they effective?	**Effective:** your care, treatment and support achieves good outcomes, helps you to maintain quality of life, and is based on the best available evidence.
Are they caring?	**Caring:** staff involve and treat you with compassion, kindness, dignity and respect.
Are they responsive to people's needs?	**Responsive:** services are organised so that they meet your needs.
Are they well-led?	**Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Source: CQC 2017

In total, we identify six key characteristics of high-quality social care that we think should shape the future of provision across the country. We argue that care should be: accessible, personal, relational, preventative, joined-up and safe. These characteristics are already present in numerous places across the system, with best-practice examples set out in the case studies in this chapter, but too many care providers are failing to learn from the best. There is a significant postcode lottery in care that must be addressed in order to deliver high-quality care for all.

We argue that care should be as follows.

1. Accessible

This means delivering care at the right time and in the right place. This is partly about reversing the rationing seen in recent years and giving more people access to care at lower levels of need. But it's also about changing where and how care is delivered. People with lower-intensity needs should be supported in their home or in supported accommodation, with a care home or hospital the last resort.

CASE STUDY: RETIREMENT COMMUNITIES

Making care accessible means ensuring support is available to people when they need it, in the most convenient location for them. The evidence is clear that most people want to remain in the community and independent for as long as possible. To enable this, there are a range of new care models being developed. One example is retirement communities (sometimes referred to as 'extra-care housing').

Retirement communities consist of purpose-built, self-contained homes to help people maintain independence as they age. Features usually include flexible, onsite care provision, 24-hour staffing, and dining and leisure facilities. Currently, 75,000 people live in retirement communities (around 0.6 per cent of the older population) but this is significantly lower than in comparable countries.

There are a number of evidenced benefits of retirement communities, including:

- reduced risk of hospital admission, with unplanned hospital admissions down from 8–14 days to 1–2 days over a 12-month period (Holland 2015)
- reduced risk of – and delayed need for – care home admission (ibid)

- a reduction in incidences of social isolation and loneliness (ibid)
- reduced cost of social care at both lower and higher levels of social care needs (ibid)
- reduced cost to the state, including the NHS (ibid).

2. Personal

This means tailoring care around the wants and needs of the individual. It will require professionals to listen to and co-produce care plans with the individual. Empowerment will sit at the heart of the system, with professionals supporting people to take ownership over their own lives rather than doing things to and for them.

3. Relational

This means treating care as a relationship rather than a transaction. It recognises that the practical elements of care – such as washing and taking medication – are necessary, but not sufficient to deliver high-quality care. Good care includes attending to the social connections the individual has with their neighbours, family, friends and local communities, and requires empathy for their loved ones and family members.

CASE STUDY: SHARED LIVES

Social care is often transactional rather than relational, with a task-based 15-minute model, often performed by numerous different carers. This severely limits quality and continuity of care, as well as peoples wellbeing as they get older. Social care should be both 'social' and 'caring': too often it is neither. But there are a range of new models that are being developed which look to address this.

One of the best known is Shared Lives. This is a membership body which trains potential carers (ordinary people in the community) and matches them with adults who need support. Carers welcome elderly people (or those with learning difficulties, physical disabilities and mental health issues) into their families or communities, and often into their home, as an alternative to traditional care services in residential institutions.

Currently, more than 9,000 Shared Lives volunteers are now supporting more than 13,000 vulnerable adults across the UK. These carers are paid, but the evidence is clear that this still saves significant money (for the individual or the local authority) – up to £26,000 per year compared to the cost of residential care (Nesta 2018). This model has also been demonstrated to deliver significantly better outcomes, particularly with regard to social isolation and loneliness.

3. Preventative

This means intervening earlier to maintain people's independence – through engendering purpose, connection and agency – for as long as possible. This will require the system to move away from rationing care for only those with complex needs. It will demand an assets-based approach, where care is built around the individuals' capabilities rather than just their needs.

CASE STUDY: LOCAL AREA COORDINATION

The majority of existing service provision focusses on people's deficits and needs. Often, support is not available until the person is in crisis, and then only to meet the need that has a service solution already designed and available. This system is failing to prevent ill-health, frailty and dependence in older age. A set of new interventions are attempting to change this by engaging earlier and focussing on people's assets and how they can be developed to maintain independence for longer.

A well-respected and evidenced model of how to achieve this is local area coordination. In each local community, a local area coordinator is recruited to work with older people (Broad 2018) in order to:

- develop their own vision for a good life
- recognise their own strengths and real wealth
- get information about what is available
- make use of and build on their own networks
- strengthen their voice
- take practical action for change
- create new opportunities within the community
- use local services and personal funding where relevant.

This approach was first developed in Australia in the 1980s, but has since been adopted across the developed world, including in some areas in England such as Thurrock and Derby City. The results across these examples are clear: local area coordination improves quality outcomes, reduces usage of the NHS, and delays costly institutional care (TLAP 2018b). Estimates show a social return on investment of £4 for every £1 investment (ibid).

4. Joined-up

This means caring for the whole-person and not just dealing with each caring need individually. This will require the system to provide support for physical, mental and social needs simultaneously. Caring activities should be undertaken by the least number of people possible in order to enable relationships and continuity. Technology should enable better communication.

CASE STUDY: BUURTZORG

Care for the elderly is often fragmented with multiple different professionals from the health and social care system administering care during a day or week. This can be distressing, lead to uncoordinated care, and inhibit the development of meaningful relationships between the carer and elderly person. An alternative model known as Buurtzorg has been developed in the Netherlands and subsequently applied in other countries (including the UK) as well.

Buurtzorg is a unique district nursing system which has garnered international acclaim for being entirely nurse-led and cost-effective. The Buurtzorg model gives far greater control and autonomy over patient care to the nurse, who undertakes all health and care-related tasks (rather than tasks being segmented across a number of specialisms). The model consists of small self-managing teams, each with a maximum of 12 nurses. Teams provide

coordinated care for a specific catchment area, typically consisting of between 40 and 60 patients.

Although this model relies on highly-qualified nurses undertaking more simple tasks (such as washing and helping people get dressed), Buurtzorg has been shown to cut long-term care costs by between 30 and 40 per cent (RCN 2016). It has also been shown to deliver more integrated care, higher levels of patient satisfaction, higher staff satisfaction and a reduction in emergency healthcare usage.

CASE STUDY: ENHANCED HEALTH IN CARE HOMES

Nearly 340,000 older people in England live in residential or nursing care homes. These care homes either provide 24-hour nursing care (nursing homes) or personal care only (residential care homes), but do not usually provide for their residents' more complex healthcare needs. As a result, there is some evidence that the healthcare outcomes for patients in residential care can be lacking (CQC 2017), with negative results such as unnecessary, unplanned and avoidable admissions to hospital, and sub-optimal medication (Smith et al 2015).

To address this, NHS England has worked with six local areas to develop a new care model for enhanced health in care homes (EHCH), intended to improve the health care provided to care home residents and reduce hospital use. This has new model has three key aims:

- to ensure the provision of high-quality care within care homes
- to ensure that, wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choosing
- to ensure the best use of resources by reducing unnecessary conveyances to hospital, hospital admissions and bed days while ensuring the best care for residents.

It aims to do this by implementing a number of evidence-based interventions, including integration between primary and acute care providers and care homes (NHS England 2016). The EHCH model is being implemented in six areas across the country.

Research by the Health Foundation has found mixed results across these areas, but a number of the enhanced health in care homes pilots were delivering better outcomes (Wolters et al 2019). For example, in Rushcliffe, they found care home residents were admitted to hospital as an emergency 23 per cent less often than a comparison group, and had 29 per cent fewer A&E attendances; Nottingham City care home residents had 18 per cent fewer emergency admissions and 27 per cent fewer potentially avoidable admissions than a comparison group; and Wakefield residents had 27 per cent fewer potentially avoidable admissions.

5. Safe and stable

This means care should 'do no harm'. The environment should be safe and clean, with people well-nourished and supported. Everyone must feel free and able to be themselves. It also requires consistency in care: care providers should be financially stable, with any potential market exit (bankruptcy) managed to reduce stress to the individual.

3.
DRIVERS OF HIGH-QUALITY CARE

LIMITS, CAVEATS AND OUR APPROACH

This chapter will set out what we know about what drives quality in social care. However, before proceeding, it is worth recognising that we have an extremely limited evidence base to draw on. This is partly because, while a lot of data exists, it is often not measuring the right things, not comparable across areas, or not publicly available (FCC 2019). It is also because there has been less investment in research in social care compared to other areas of policy (such as health) (ibid). The result is that, in too many areas, we have to base our conclusions on limited evidence and data.

In this context we have a choice: we can use what evidence there is to make a calculated guess about what policies might improve quality, or we can maintain the status quo until we have better evidence. We argue that we must invest in improving data quality for the future, but that, in the meantime, we know enough to act in order to deliver a better life for older people. In this chapter, we highlight the three main drivers of quality in social care as identified through our qualitative research and the wider literature on this topic.

FUNDING

Social care spending fell consistently during the first half of the decade (see figure 3.1) as a result of cuts to local government budgets, despite attempts by local authorities to protect social care. Since then, the social care budget has been growing but it has still not met its pre-austerity peak of £22 billion. This record is made all the more staggering because, while resources have been declining, demand has been increasing – with a growing and ageing population requiring more care.

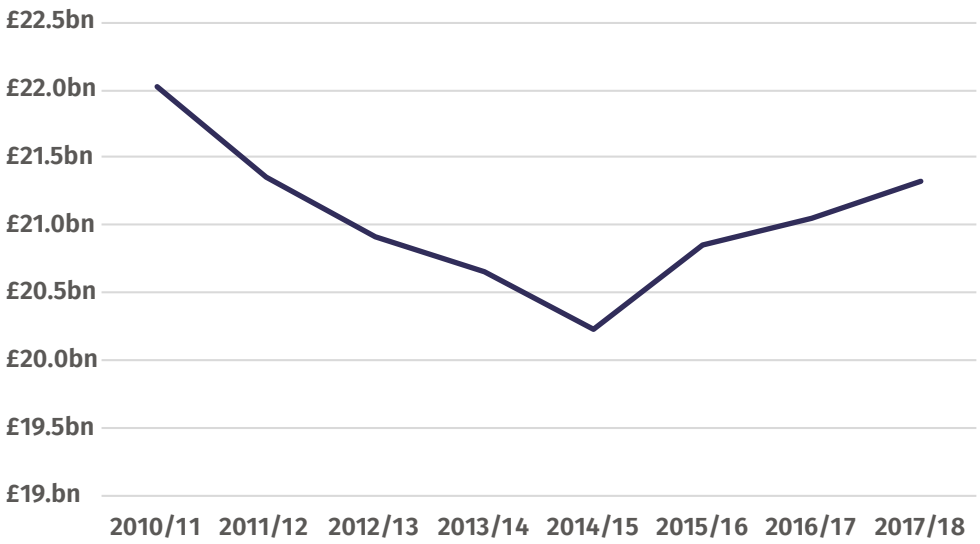
Local authorities have responded to this pressure by reducing access to adult social care. Between 2009/10 and 2013/14, the total number of adults receiving publicly-funded care fell by about 400,000 (Thorlby et al 2019). This trend is likely to have continued, but a change in data collection in 2013/14 makes this hard to verify. These reductions were probably a result of tightening needs thresholds and a failure to uprate the means threshold (ADASS 2018; NHS Digital 2019).[1]

The result has been a significant increase in the number of people having to self-fund, rely on family members for care, or to go without. There are 1.4 million people aged 65+ who face unmet social care needs – over double the number in 2010 (Age UK 2018). The gap between need and provision is greatest for those on lowest incomes, with those on higher incomes paying for care privately (Health Foundation 2017). This has also put huge pressure on informal, and unpaid, carers (often family and friends) whose labour is now valued at over £132 billion annually (Buckner and Yeandle 2015) – a figure that has risen significantly over the last decade.

1 In the ADASS budget survey 2018, 75 per cent of adult social services directors said that reducing the number of people in receipt of care was important or very important to their planned savings in 2018/19. See: https://www.adass.org.uk/adass-budget-survey-2018

FIGURE 3.1: ADULT SOCIAL CARE FUNDING HAS FALLEN BY £700 MILLION SINCE 2010/11

Adult care social funding (£bn) in England by year, 2010–18



Source: Bottery et al 2019

This is undoubtedly a national scandal: security and support in older age is a basic right, not a luxury. However, in reducing access, it appears that local authorities have been able to maintain or improve the quality of care provided to those who do have access to it. In 2018, 82 per cent of care providers were rated 'outstanding' or 'good' by CQC, up from 80 per cent the year before (though this may be the result of how providers are regulated)[2] (CQC 2017). Moreover, self-reported outcomes among social care users have also largely improved (Darzi et al 2018).

However, the evidence now suggests that social care is fast approaching a 'tipping point', where the drivers of quality are overcome by budgetary pressures (CQC 2017; ADASS 2018). This is because the strategy so far adopted by local government, of improving efficiency and restricting access, is fast running out of road. Moreover, there is significant variation in the quality of provision across the country (see figure 3.2 for data on care home quality).

Furthermore, there are two further channels through which funding is likely to impact on quality in social care.

Firstly, the one indicator of quality where performance has not improved over the last decade is 'social connection', with fewer than half of social care recipients in every area across England satisfied with their level of social connection (Darzi et al, 2018). This is likely to be (partly) the result of commissioning decisions by local authorities who have responded to cuts by protecting statutory duties but cutting non-statutory obligations such as local community assets and other services such as Supporting People[3], day centers and community transport for the elderly. Any

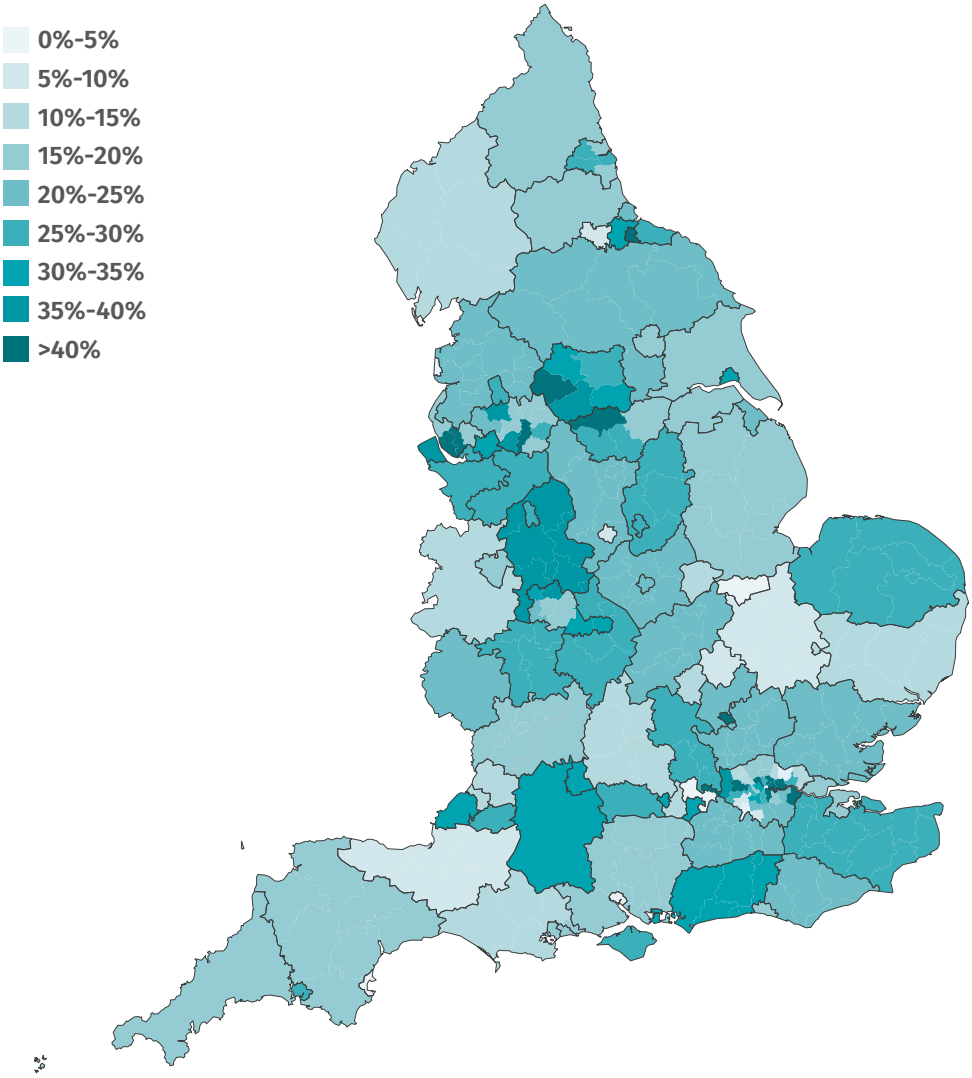
2 This is because not all care providers are inspected every year, and those rated as inadequate one year are prioritised for re-inspection first. Those that are rated as good or outstanding will have to wait longer for re-inspection and could have declined in the meantime.

3 Supporting People brought together seven housing-related funding streams from across central government into a single programme, funded by the Department for Communities and Local Government (DCLG) and was administered by local government. It was used to provide housing-related support services for vulnerable adults in order to help them maintain their independence.

new funding settlement must therefore allow for the proper funding of community services such as the above as well as funding for statutory social care obligations.

FIGURE 3.2: THERE IS SIGNIFICANT VARIATION IN THE QUALITY OF CARE ACROSS ENGLAND

Percentage of care home beds rated 'inadequate' or 'requires improvement' by local authority area, 2019



Source: FCC 2019

Secondly, as a result of the cuts to local authorities, there is a strong consensus that their strategic and management capacity has been diminished. This was a repeated theme of our qualitative research for this project. This is vitally important: local authorities have an obligation under the Care Act 2014 to perform a market shaping and monitoring function to ensure everyone has access to high-quality care. Our qualitative research found that they do this best when they take an active partnership approach to commissioning services, rather than simply overseeing transactions. But they can only perform this role if they have the capacity to do so.

WORKFORCE

There is a strong consensus in the sector that workforce is a significant driver of quality (CQC 2017). In particular, the CQC has identified a link between high vacancy and turnover rates, and poorer levels of care being provided (ibid). Others have highlighted that staffing levels are closely related to the time available to carers to provide personalised care and build relationships with those they are caring for (Dromey and Hochlaf 2018). Meanwhile, carers themselves highlight that a lack of training and support inhibits their ability to provide high-quality care (Unison 2017).

CQC (2017) also highlight that leadership amongst managers is crucial for high-quality care.

> ***"At registered manager level, strong leadership was characterised by individuals with an innovative, outward or forward-looking approach who were open to feedback and actively sought out best practice to steer improvement. Managers were visible in the service, and known to staff, people using the service, carers and families ... Good managers truly valued their staff, supporting them to maintain their knowledge of best practice and person-centred care through training and establishing 'champions' in different areas of care."***
>
> CQC 2017

This point was consistently reiterated in interviews with local commissioners, who argued that the capability of the care provider managers was the single consistent determinant of provider quality (or failure) in their area.

These conclusions are concerning because the sector is currently facing a workforce crisis. There is a considerable shortage of workers with a vacancy rate of 7.8 per cent of roles, increasing to 9 per cent for care workers and 11.4 percent for care managers (Skills for Care 2019). It also has a very high turnover rate of over 30 per cent (although over half of these remain within the sector) (see figure 3.3). And these pressures are expected to grow, with restrictions on freedom of movement as the UK leaves the European Union and the government's proposals on immigration posing a particular risk to staffing levels.

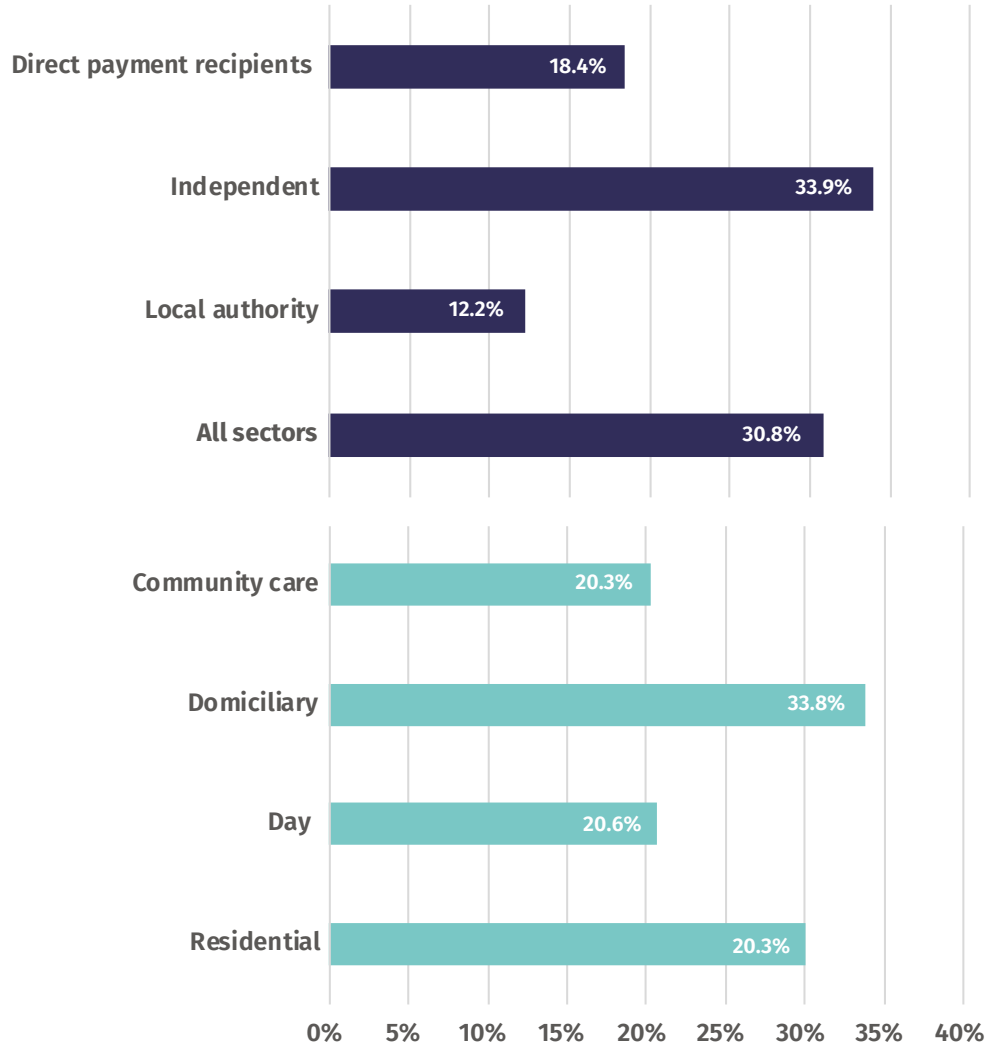
The workforce crisis is not just about a shortage of workers but also about the skills they have. While some occupations in the sector, including registered nurses, social workers and occupational therapists, are regulated professions with rigorous training requirements, care workers have no professional regulation and no mandatory training. Unsurprisingly, Skills for Care (2019) find that over half (51 per cent) of the social care workforce have no relevant social care qualifications (though this figure is lower for frontline carers).[4] This speaks to the urgent need to upskill and properly value the care workforce.

The causes of this workforce crisis are not a mystery. First, the adult social care sector is characterised by endemic levels of low pay, with nearly half (43.4 per cent) of all jobs in social care paid below the real living wage in 2018 (Dromey and Hochlaf 2018). Second, working conditions are poor, with travel time often not reimbursed (pushing the wages of staff even lower), staff often undertaking unpaid overtime, and many on zero-hours contracts (ibid). And finally, there is a clear lack of career progression; analysis by Resolution Foundation shows that workers in social care are among the least likely to escape from low pay (D'Arcy and Hurrell 2014). These are the issues that need addressing to drive up quality in the sector.

4 It should be noted that such qualifications may not necessarily be required of staff who do not provide direct care (including ancillary and administrative staff).

FIGURE 3.3: SOCIAL CARE HAS HIGH LEVELS OF STAFF TURNOVER

Estimated staff turnover rate by sector and care service, 2018/19



Source: Skills for Care 2019

PROVIDER TYPE

There is some evidence that the provider type and their business model has an impact on quality. Future Care Capital's analysis of CQC data shows that, on average, private residential care providers deliver lower quality of care than those delivered by the voluntary and state sector, as measured by CQC ratings (see figure 3.4). This is particularly concerning because the CQC data also reveals that private providers make up the vast and growing share of providers in the sector - with 84 per cent of residential care beds provided by the private sector – up from an estimated 82 per cent in 2015[5] (FCC 2019) (see figure 3.5).

5 Note: this is an estimate because of changes in the way this information is collected.

FIGURE 3.4: PRIVATE PROVIDERS OF RESIDENTIAL CARE TEND TO HAVE WORSE CQC RATINGS THAN THE VOLUNTARY AND STATE SECTOR

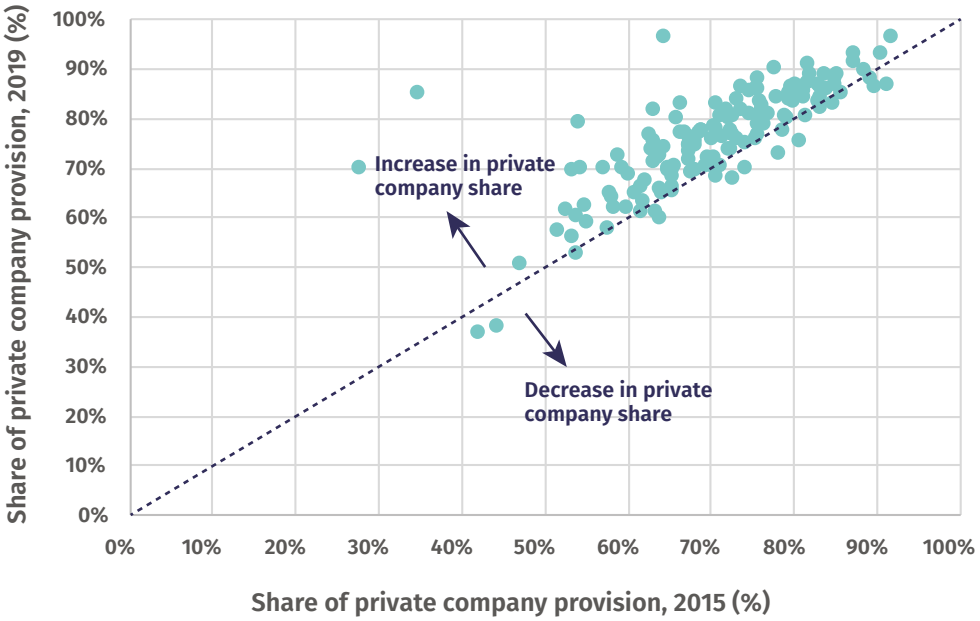
Percentage of providers rated 'inadequate' or 'requires improvement' by the CQC, 2018

		2019
Private	Company	24.8%
	Partnership	20.8%
	Individual	20.8%
Public	Councils (mostly)	17.4%
	Hospital (mostly mental health)	14.6%
Not-for-profit	Charitable company	16.4%
	Charity not registered as a company	15.8%
	Registered society (mutual)	12.0%

Source: FCC 2019, analysis of CQC 2019

FIGURE 3.5: PRIVATE PROVISION OF RESIDENTIAL CARE AS A SHARE OF RESIDENTIAL BEDS HAS INCREASED IN 91 PER CENT OF LOCAL AREAS SINCE 2015

Share of beds run by private companies, 2015–19



Source: FCC 2019, analysis of CQC 2019

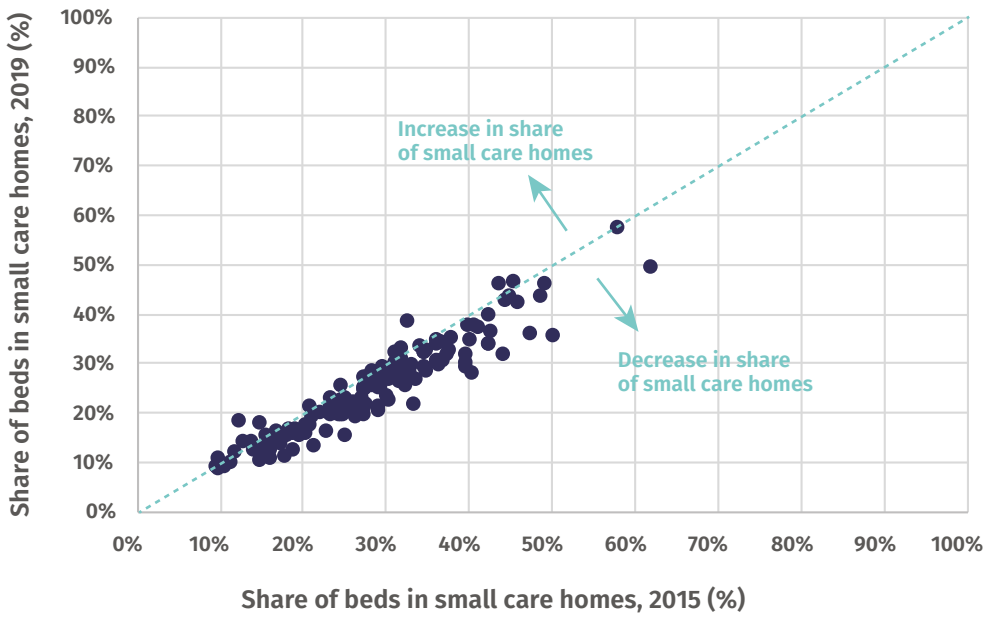
These findings are corroborated by a range of academic studies (both of providers in the UK and abroad), which, in general, find a negative correlation, meaning that for-profit providers and areas with higher levels of competition deliver lower-quality care (Forder and Allan 2011; Rosenau and Linder 2003; Devereaux et al 2009). For example, a systematic review and meta-analysis published in the *British Medical Journal* found that, of 82 studies published between 1965 and 2003, around half found that for-profit providers delivered worse care, compared to just three which found favourable results for private providers (Devereaux et al 2009).

Several channels are suggested by the literature for this link between ownership model, competition and quality, including the following.

- **Workforce:** There is strong evidence that private providers have lower levels of staffing, higher staff turnover, lower rates of pay, and lower levels of training (Dromey and Hochlaf 2018). As set out above, these factors are closely related to levels of quality (CQC 2017).
- **Instability:** The care market has grown increasingly volatile, with three-quarters of local councils experiencing provider closure – up from two-thirds the year before (ADASS 2019). There is evidence that provider closure can result in higher levels of resident distress and mortality (Hallewell et al 1994).[6] This is particularly problematic with the big providers, who supply up to 30 per cent of the beds in some areas.
- **Size:** There is a link between the size of a provider and quality of provision in residential care. Of both small nursing and residential homes, 89 per cent are rated as 'good' or 'outstanding' by the CQC, compared with just 65 per cent and 72 per cent of large nursing and residential homes respectively (CQC 2017). This is particularly concerning because small care homes are increasingly exiting the market (figure 3.6).

FIGURE 3.6: THERE HAS BEEN A DECLINE IN SMALL CARE HOME PROVIDERS IN 91 PER CENT OF LOCAL AREAS SINCE 2015

Share of beds provided by small care homes, 2015–19



Source: FCC 2019

It is important to recognise that this data - and the studies referenced - show general trends across providers. There are many private care companies that provide excellent care for those they serve, just as there are voluntary sector or state providers that fail to meet the standards, we expect of them. A simple 'state is good, private is bad' narrative is too simplistic. Instead, our qualitative research suggests that it is the business and care models adopted by the providers that determines quality.

6 Though others argue that contestability and market exit can also improve quality.

Specifically, care providers that put people at the heart of their business and care model tend to deliver higher quality care. This is highlighted by the CQC who find that "good leadership that generates a positive and inclusive culture leads to genuinely person-centred care" (CQC 2017). Those without a caring culture - often with a focus on profit - tend to cut corners (such as low pay or lack of training for staff) or deliver more transactional care (such as larger care homes with less personalisation). A transformational agenda in social care would spread the former while pushing the latter out of the market.

4.
DELIVERING HIGH-QUALITY CARE

A RADICAL REFORM PLAN FOR CARE

In the context of an ageing population, social care has a vitally important role to play in the functioning of a good society. At its best, it can help people maintain their independence, purpose, meaning and social connections as they age. This is demonstrated by a growing number of innovative models of care, in communities, people's homes and in formal care settings – pointing the way towards a brighter future.

However, these providers are still the exception rather than the norm, with many in the sector failing to deliver high-quality care for all. To address this, social care desperately needs a long-term funding settlement. But money alone will not transform the sector. We need a bold reform plan in order to ensure that this investment spreads best practice and stamps out inadequate provision and outdated models of care. This chapter looks to define the parameters of such a reform plan.

A LONG-TERM FUNDING SETTLEMENT

Delivering high-quality care for all is about more than just money. But a long-term funding settlement is a prerequisite of the transformation agenda we have set out in this paper. IPPR has previously set out its proposals for funding social care in the future, calling on politicians to commit to introducing free personal care in England, so that nursing and personal care is free at the point of need, just like the NHS (Quilter-Pinner and Hochlaf, 2019).

Modelling by the Health Foundation shows that this would require an additional £6 billion per year by 2020/21 and £8 billion per year by 2030/31 (Bottery et al 2018) (see figure 4.1). However, additional investment is needed on top of this to keep up with demand pressures. This would cost up to an additional £4 billion per year by 2020/21, and £12 billion by 2030/31 (ibid). We have previously called for this to be funded through increases to general taxation (income tax or national insurance) (Quilter-Pinner et al 2019).

> **Policy recommendation 1**
> **Introduce free personal care in England and commit to meeting demographic pressures at a cost of up to £10 billion per year by 2020/21. This should be funded out of increases in general taxation.**

However, as our research has shown, just funding the statutory obligations of local government will not enable high-quality, asset-based and preventative social care. For this, local government also need to invest in a range of community assets and public services (such as libraries, parks and transport), and also wider service offerings (such as housing support, employment support). This points to the need for not just a long-term funding settlement for social care, but also for local government overall.

FIGURE 4.1: FREE PERSONAL CARE REQUIRES SIGNIFICANT ADDITIONAL INVESTMENT IN THE ADULT SOCIAL CARE SYSTEM

Cost of alternative policies in adult social care

		Current system		Reforms	
		Maintaining at 2015/16 levels	Restoring to 2009/10 levels	Cap and floor	Free personal care
2020/21	Projected cost pressures	£21bn	£27bn	£25bn	£26bn
	Increase from 2015/16 spend of £17.1bn	£4bn	£10bn	£8bn	£9bn
	Additional cost above maintaining 2015/16	N/A	£6bn	£4bn	£6bn
	Projected funding available	£19bn			
	Extra funding required	**£1.5bn**	**£8bn**	**£5bn**	**£7bn**
2030/31	Projected cost pressures	£29bn	£39bn	£35bn	£37bn
	Increase from 2015/16 spend of £17.1bn	£12bn	£22bn	£18bn	£20bn
	Additional cost above maintaining 2015/16	N/A	£9bn	£6bn	£8bn
	Projected funding available	£23bn			
	Extra funding required	**£6bn**	**£15bn**	**£12bn**	**£14bn**

Source: Bottery et al 2018

Furthermore, our research has also been clear that to deliver transformation there is an urgent need for capacity in the system, at both commissioner and provider level, in order to drive and manage change. There is also therefore a need for a transformation fund for social care with an explicit aim of spreading best practise models across the country. This could pay for management capacity, infrastructure costs and double running costs. This could be funded in the first instance by top-slicing the funding put into maintaining access (set out above) but would ultimately pay for itself through increases in productivity.

Policy recommendation 2

Create a social care transformation fund worth £2 billion over five years (£400 million per year) to spread best practice care models by top-slicing the new social care funding settlement.

A 'NEW DEAL' FOR THE WORKFORCE

The main determinant of quality in social care is its workforce. For too long, social care workers in the UK have been under-paid, under-valued, and under-supported. This must change now: they perform a vitally important role in society and deserve to be treated better. We therefore call for any new investment in the social care system to come alongside a 'new deal' for the social care workforce. This should include three key elements.

First, we need to end low pay in the social care sector which is resulting in staffing gaps, high turnover and lower skills levels. As part of a new ethical commissioning charter (see next section), all social care providers receiving state funding should be required to pay at least the real living wage. Based on 2018 pay levels, this would come at an additional cost to providers of £740 million (with around £500 million falling on the state) (Dromey and Hochlaf 2018). In the longer term, we should go further and commit to aligning pay in the social care

to that in the NHS. This would also help to creates routes for job progression across health and social care.

Policy recommendation 3
All social care providers receiving state funding should be required to pay at least the real living wage. In the longer-term, government should commit to equalising levels of pay in the NHS and social care.

Second, further measures are needed to boost pay across income distribution and to improve working conditions in order to tackle the growing workforce crisis. We argue that this should be delivered through a new system of sectoral collective bargaining for adult social care. This is the process of negotiating between trade unions and employers to agree terms and conditions of employment. It is currently used in the NHS but not in social care. This must change. Care workers will need more voice and agency to ensure the profession is well respected and therefore well-staffed.

Policy recommendation 4
Introduce a new system of sectoral collective bargaining for social care workers, similar to the system operated in the NHS.

And, finally, in order to support the professionalisation of social care, the care certificate should become a robust and mandatory licence to practise for all care workers. This is standard practice for other caring professions; for example, nursing, which requires extensive initial training, ongoing continuing professional development (CPD) and professional registration with the Nursing and Midwifery Council. In addition, Skills for Care should be merged with Health Education England (to be renamed Health and Care Education England) and properly resourced in order to improve the status of social care workforce planning and join it up with the NHS.

Policy recommendation 5
The Care Certificate should become a robust and mandatory licence to practise for all care workers.

Policy recommendation 6
Skills for Care should merge with Health Education England and should be given a significant budget increase.

AN ETHICAL COMMISSIONING AGENDA

A future reform agenda will need to use state funding – which is and will continue to be considerable – to drive through changes in the business and care models operating across the sector. This is necessary to ensure that all care is provided with a focus on the interests of the care recipients, and wider society, rather than simply profits in mind. We argue that, to achieve this, government should introduce a new ethical commissioning charter that will determine who provides care.

This charter would demand that all providers receiving state funding meet certain ethical conditions in order to drive quality and value for money for the taxpayer. Our research suggests that this should include compulsory conditions, set at a national level, across three key domains.

1. **Workforce:** Contracts should only be awarded to organisations that pay the real living wage, provide adequate training and support and engage in sectoral collective bargaining.
2. **Quality:** Contracts should only be awarded to organisations with a track record of high-quality care (or, in exceptional circumstances, organisations with a clear plan for improvement or new providers with promising new care models).

3. **Transparency:** Contracts should only be awarded to organisations that can evidence that they pay their fair share of taxation, that they are financially sustainable, and that they are prepared to share key data they generate with commissioners in order to facilitate monitoring of provider stability and quality (see recommendation 7).

It should also include optional conditions across a further two domains.

1. **Economy:** Preference should be given to local organisations that can demonstrate the economic and social value to local communities, including job creation.
2. **Environment:** Preference should be given to organisations that can evidence high environmental standards and actions to limit waste.

This agenda would not demand that all services are insourced. Nor would it arbitrarily give preference to organisations with specific ownership models. Such an approach would be too simplistic. Instead, it would look to determine who provides care based on their ability to meet the ethical and quality standards we should expect of organisations providing care to some of the most vulnerable people in our society.

Policy recommendation 7

All social care providers should be required to meet basic standards on workforce pay and conditions, quality of care and their financial management.

An explicit objective of this strategy would be to force failing providers out of the market and encourage the entrance or expansion of more innovative, socially-minded providers. In doing so, we would expect to see a rebalancing in the market towards the state and the voluntary sector. Indeed, such a model may well require the state to step in and provide care if, as a result of the standards demanded, existing providers leave the market. To facilitate this, as well as filling gaps in the provider market (areas with a lack of provision), we recommend the creation of a £7.5 billion Ethical Provider Fund (over the next decade) to facilitate the creation of new care providers. This should include building new residential or extra-care housing (as the state can do this at lower cost than the private sector) (Blakeley and Quilter-Pinner 2019) with the care either provided by the state or outsourced to innovative providers.

Policy recommendation 8

The government should provide up to £7.5 billion of funding to create innovative new ethical providers, including funding for capital costs for new residential care homes, to be run by the state, social enterprises or voluntary sector. Care support could be provided by the state or outsourced.

DATA THAT CARES

Care is a basic human need. Care providers look after some of the most vulnerable people in our society, yet we still know very little about them. This is because of poor data availability and research in the sector (FCC 2019). A clear finding from our research is that, with current data availability, it is challenging for commissioners and regulators to perform their legal functions, such as market shaping and oversight, as well as monitoring provider performance.

As part of the transparency element of the ethical commissioning charter, we argue that all care providers receiving state funding should be required to submit to 'open book' regulation. We recognise that

local authorities may not have the capability to understand all of this information, particularly for larger firms with complex financial structures. We therefore argue for the expansion of the CQC's market oversight function into a more comprehensive financial regulator: OfCare. This is currently limited to the largest 60 firms (both domiciliary and residential), which together make up 25 per cent of the market, and is under-resourced.

In addition, we argue that there is a need for comprehensive review of quality metrics and data in the sector. There is currently limited data on quality (just CQC ratings and the Adult Social Care Outcomes Framework), with even less for those who are not receiving state funding (FCC 2019). This review should allow for better quality regulation in the sector and implementation of the ethical care charter, as well as facilitate the development of evidence-based policy.

Policy recommendation 9

Expand the CQC's Market Oversight function to cover all medium and large care providers in the form of a financial care regulator: OfCare.

Policy recommendation 10

Undertake a comprehensive review of quality metrics and data in the social care sector and mandate local providers to collect and publish it.

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