INSTITUTE FOR GOVERNMENT

Adult social care

Short-term support and long-term stability

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Introduction

During the ongoing winter NHS crisis adult social care has found itself in the spotlight for the role it plays in delaying discharge from hospitals. While this role may be overstated,[1] a lack of social care provision has certainly contributed to hospitals' poor performance on patient flows. But away from hospitals adult social care also encompasses a critically important range of care and support services in its own right.

It is a service that should enable people to live their lives to the fullest or, as a witness to the House of Lords Adult Social Care Committee described it, to live "a gloriously ordinary life".[2] However, fewer people are now receiving such support, with 12.3% and 5.4% per capita declines in the number of people receiving publicly funded long-term and short-term care packages respectively between 2014/15 and 2021/22. This is despite an ageing population with an increasing demand for care.

That lack of provision is the result of historic underinvestment in the service. Government spending on adult social care fell in real terms throughout the first half of the 2010s, before climbing in the second half of the decade but only reaching 2009/10 levels again in 2019/20. This has made it more difficult to invest in the workforce: the long-standing staffing crisis in adult social care is now arguably more severe than the higher profile one in the NHS. This makes it difficult to provide the desired level and standard of care, particularly domiciliary care, but also in nursing and residential care.

The pandemic has also played a part. People who did not come forward for care during the worst of the crisis are now, according to some of those we spoke to, presenting with more complex needs, putting additional strain on the already stretched service.

These short-term issues cause problems now, but also contribute to longer-term challenges facing the sector. With an ageing population and the continued growth in requests for care from working-age adults, there will need to be ongoing and substantial revenue and capital investment in the social care sector so that it can support people to live the lives they want to live.

While care homes will be the best option for a only minority of this number, this part of the sector has a particularly acute need for capital investment. Many of the current beds are in large old buildings that are ill-suited to implementing infection prevention and control measures, the consequences of which were felt during the early months of the Covid pandemic. They are also less appropriate for those now entering care homes, who increasingly require more specialised dementia and nursing support. Attracting capital investment, therefore, will be key to bringing the care home estate up to the standards required of modern care. With around 89% of care home places provided by the independent sector, much of that capital investment will come from private markets.

This report explores these short- and long-term problems in more depth, with a particular focus on care homes, and evaluates the role that government could play in addressing them. Insights in this report are based on a roundtable and interviews with senior stakeholders from central and local government, care providers, the investment sector and think tanks with expertise in social care.

Short-term, emergency funding is not a good way to fund adult social care

To alleviate the pressure in both adult social care and secondary care – health care provided in hospitals – the government has fallen back on an old response of issuing short-term, emergency pots of money. So far in 2022/23, the government has made £500 million a year for three years available as part of the Adult Social Care Discharge Fund (announced in September 2022)[3] and a further one-off £200m available as part of another unnamed fund announced in January.[4] This money is primarily intended to increase capacity in adult social care, with the goal of improving the speed of discharge out of hospital into social care services. There are, however, several problems with this approach.

First, social care providers are unable to ramp up supply fast enough to make a material difference to discharge problems this winter. This is partly because provision is so closely tied to staffing levels in adult social care and staffing levels are not that responsive to this type of funding. It takes time to hire and train new staff, meaning that funding provided in January is unlikely to make much difference to staffing levels in the immediate future. Recruiting lots of additional staff is also likely to require raising

wages, something that providers are unwilling to do given that some funding will run out after winter; it is easy to raise wages, but hard to drop them again when funding ends. It is also difficult to convince staff to work for only a limited number of months, before funding runs out.

Attempting to rapidly expand capacity in an emergency means the government will receive worse value for money (VfM) than if it had invested in the service's capacity over a longer period of time. Part of this is because, as previously discussed, it is expensive to rapidly expand the workforce temporarily. One solution for this is to increase the use of agency staff. These staff members are hired on a shift-by-shift basis, meaning that providers have no obligation to continue employing them once funding runs out. But agency staff are also more expensive to employ per shift than permanent counterparts and the quality of the care they provide is harder to ensure. Providers are also likely to charge more for the same service than they would do in non-emergency situations, with some reports that providers charged twice their normal fees in January this year.[5] When there is limited capacity but increased demand, prices will likely rise.

This is another example of the inefficient cycle of 'crisis-cash-repeat' that has characterised the government's approach to public services since 2015.[6]

Funding is provided late and with little notice

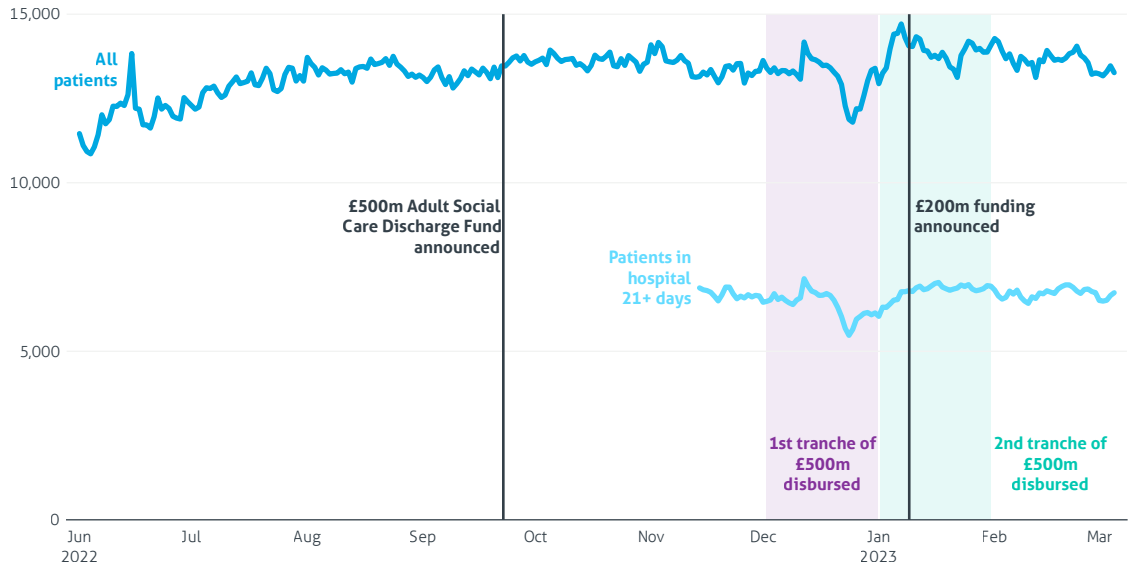
Despite announcing the Adult Social Care Discharge Fund in September 2022,[7] the first tranche (40% of the total) was not disbursed until December, with the second disbursed in January 2023 (60%).[8] The additional winter pressures fund was announced in January, though it is unclear over what time frame that money is being disbursed to the NHS and local authorities. This means all three funding packages have come too late to make a meaningful difference to care capacity – and so improve delayed discharge. This is because there are many intermediate stages in the adult social market between the source of funding (central government) and providers: money must pass first through local authorities, who then commission care based on demand and availability, and only then pay providers. In addition, central government also often attaches stringent terms and conditions to funding,[9] placing an administrative burden on both local authorities and providers at a time of already limited capacity and resources.*

Indeed, there has been little improvement in the number of people who remain in hospital despite being eligible for discharge since September. It is true that the situation may have been worse without the funds. However, the most recent data shows that by 5 March there was only a 2.6% decline in the number of people who no longer met the criteria to reside, and a 4.4% increase in the number of people who are eligible for discharge but who have been in hospital for more than 21 days since 1 December 2022.

* For example, the Adult Social Care Discharge Fund comes with the condition that local authorities create a plan for how they would spend the money, before then having to submit fortnightly activity reports, with a final report in May 2023. The funding must also be rolled into the existing Better Care Fund, meaning that use of the money has to be agreed between local authorities and integrated care board (ICB) CEOs before finally being signed off by the health and wellbeing board.

Lastly, there has been a tendency in recent years for central government to finalise the local government finance settlement with little notice – often as little as six weeks before the start of the financial year – and use it to cover only one year of funding.[10] This makes it difficult for local authorities to properly plan how much they will be able to spend and, in turn, for providers to plan the level of supply they will provide.

Figure 1 **Delayed discharge by length of stay, 1 June 2022 to 5 March 2023**



Source: Institute for Government analysis of NHS England, 'Urgent and Emergency Care Daily Situation Reports – 2022–23: Discharge delays', ('Table 2') and ('Table 3'), 9 March 2023.

Government should learn lessons from how 'discharge to assess' worked in the pandemic

Attendees at the roundtable discussed the use of discharge to assess (D2A) during the pandemic as a model on which more effective urgent discharge could be based. D2A is a policy where hospitals discharge patients into their home, community care, care homes or any other available setting as soon as possible after they are medically eligible for discharge – but not yet discharged – and after carrying out only a light-touch assessment of care needs; the local authority then carries out a more thorough assessment once they are discharged. This is used where freeing up bed spaces in hospital is a priority for the NHS.[11] D2A predates Covid, but the NHS expanded its use during the early months of the pandemic to clear as many beds as possible.

While the NHS and local authorities are still widely using D2A, it does not seem to be as effective at freeing up beds as it was during the height of the pandemic. Roundtable attendees identified a few reasons why this might be the case. First, there were fewer workforce vacancies in the adult social care sector than there are now – 6.7% in 2020/21 compared to 10.8% at the end of December 2022[12] – which as noted above is limiting capacity and delaying discharge.

Second, there was a broad acceptance of the critical importance of clearing hospital beds during the pandemic, even if it meant discharging people into settings that, while better than an acute ward, may not have been optimal. Local authorities are less willing to facilitate discharge at any costs now, for several reasons. They may fear that without the correct reablement services available once someone has left hospital,* patients will end up in long-term care by default – a high, ongoing cost for local authorities. They may also worry that emergency spending by the NHS to increase social care capacity will raise the cost that providers charge for all places in care, again as noted above, threatening financial sustainability. And social workers themselves may also be less willing to place people in sub-optimal care settings than they were during the pandemic, in the hope that a more appropriate one will materialise.

Resistance to discharge-at-any-cost is not just coming from local authorities, however. Roundtable attendees said that care home managers might be sceptical of hospitals' assessment of an individual's needs, due to the urgency of discharging that person.

Finally, and crucially, the government provided substantially more funding for D2A during the pandemic. That money served many functions, the most important of which was reducing arguments between stakeholders about who was financially responsible for people leaving hospital and entering care. If that increased funding was available now, for example, local authorities may be less averse to discharging people from hospital without appropriate reablement services available, while it could also help fill some of the vacant roles in the service with permanent staff, which would in turn increase capacity and reduce reliance on the more expensive and arguably less effective agency staff.

The use of D2A during the pandemic was a good example of multiple organisations taking pragmatic steps to achieve a target; but it was arguably only so successful due to the specific context of the height of a crisis.

Attendees stressed that this kind of co-ordinated activity is possible in 'peacetime', but requires more trust, particularly between local authorities and providers. Providers present described being willing to ramp up capacity on the basis of a promise of future non-emergency business from local authorities, but only when there was a good existing relationship, which often meant a history of the local authority paying sustainable placement rates. They claimed this was rare, an outcome that is likely to be due in part to the uncertainty that local authorities themselves face around their future funding.

D2A was not perfect even during the pandemic, however. Some directors of adult social services (DASSs, responsible for commissioning care in a local authority) say it was a disaster. They claimed organisations fell back on it too easily, and that it tends to reduce reliance on reablement services, designed to improve independent living. The urgency to discharge patients during the pandemic also meant that many patients were discharged into care homes with Covid,[13] resulting in a large number of deaths.[14]

* Reablement services are provided after hospital discharge, normally in a community care setting, and are designed to be short-term measures that reteach an individual the skills they need to live independently. This care is normally delivered for 1–2 weeks, after which the individual should be able to live without long-term care.

Despite these issues there was a feeling that on balance D2A did help and that the current context (lower prevalence of Covid and better testing) meant that some of the key weaknesses from its use during the pandemic could be avoided.

'Pre-ablement' should be used to reduce acute admissions

There was widespread agreement at the roundtable that the best way to improve discharge issues was to keep people away from acute secondary care in the first place. This has become harder because some attendees and interviewees reported that patient needs have increased over the pandemic, due to an inability or reluctance to access support when first needed.

In response, they recommended improved care in the community that would prevent the worsening of long-term conditions, which eventually leads to higher hospital admissions. They coined this "pre-ablement" as a nod to "reablement", which as discussed is care that is designed to increase independent living following an acute episode.[15]

There was, however, a feeling among attendees that this type of care requires a different approach. Rather than treating social and community care as a means of clearing overly full hospitals, they argued that the government would instead need to move to a model where community and social care were treated as fully funded services in their own right. This change in approach would not only benefit people accessing care, but would also represent better value for money for the government. There was a widespread feeling that this would be a more effective way of spending the 'extra pound' than spending it on acute health care.

It is not just community and social care that contribute to a good quality of life, and in turn can keep people away from acute care. Wider services provided by local authorities such as housing, leisure, green spaces and transport, among others, can also play an important role. These services faced disproportionate cuts throughout the 2010s as the dual pressures of cuts to grant funding and rising demand for social care meant there was less money than ever to spend on these neighbourhood services.[16] While it is difficult to draw causal links between cuts in these services and demand for acute care, they do facilitate an individual living a fuller life, which increases wellbeing and likely improves health outcomes.

A wider forum for decision making is needed

The placement of integrated care systems (ICSs) on a statutory footing in 2022 was intended at least in part to improve communication between social care commissioners in local government and the NHS. It is too early to tell if ICSs will achieve that goal. But attendees at the roundtable did emphasise that there is still too little involvement of providers in decision making. They also said that providers are often involved in discussions only in response to a crisis, rather than as part of routine capacity planning, and that there would be benefits to bringing them in at an earlier stage.

This is in part because of the nature of the market. On one hand it is highly fragmented, with many small providers – more than a third of residential providers employ fewer than 10 people; more than three quarters employ fewer than 50[17] – making it difficult to consult them in a meaningful way on relevant decisions. On the other hand, there are also larger providers that work across different local authorities and ICS boundaries that don't have the time or incentives to engage extensively with every local authority they work with.

There is no easy solution to this problem, but engagement is likely to be easiest to co-ordinate through integrated care partnerships (ICPs).[18] With 42 ICPs, compared to 152 top tier local authorities, there may be greater incentive for larger providers to participate in decision making and it may enable the development of regional forums or representative bodies that could speak on behalf of smaller providers.

Delayed charging reforms were unlikely to solve the crisis

There was a wide-ranging discussion about the implications of the delay to adult social care charging reforms. There was a feeling that central government had not effectively communicated the extent of charging reforms and how they would impact individuals – a view that is borne out by polling on the topic.[19] For example, there is poor understanding among the public that the cap on care costs would only include personal care costs, not 'hotel' costs, meaning that there was still an open-ended (albeit lower than at present) liability for anyone who lives in nursing or residential care. Instead, there was the feeling that much of the burden of communicating the implications of the reform had fallen to local government.

There was also scepticism that charging reforms would help to alleviate some of the crisis currently affecting adult social care. This was mostly because the reforms would shift the source of funding – an increased proportion from the government – without necessarily changing the level of funding. If anything, there was concern that charging reforms would mean less funding for the service. Specifically, attendees thought that implementing Section 18(3) of the Care Act 2014 – which would have allowed self-funders to access care at the council-funded rate, thus ending the cross-subsidy between those people and those receiving care subsidised by the local authority[20] – would have meant less money entering the service overall.

This would have severe negative implications for the level of social care provision. Currently, self-funders pay fees at a level that enables providers to be sustainable and justifies investment by them in the service. The fair cost of care (FCC) is designed to compensate providers for the loss of money from self-funders. However, despite the sector initially welcoming this single cost of care, widespread scepticism has emerged about whether the FCC exercise would provide sufficient funding for the service. Attendees and interviewees felt that because it was backwards looking, it failed to capture the ongoing costs that providers would incur (particularly in a period of high inflation) and 'baked-in' the current levels of poor quality care that the government should be aiming to improve on.

Many local authorities were relieved when the charging reforms were delayed in November 2022. This was mostly because it reduced the financial pressure from funding the FCC, the cap and the more generous means test in the short term. But it was also because they would struggle to meet the increased demand for assessments that would come with the reforms. There were 0.6% fewer social workers (responsible for care assessments) in local authorities in 2022 compared to 2019,[21] and insufficient financial assessment officers (who conduct means tests for care applicants) to meet demand.

Service performance will only improve after the workforce crisis is resolved

The one problem that came up repeatedly when discussing the problems in adult social care was the difficulty of attracting and retaining sufficient staff. This workforce crisis prevents the expansion of social care supply even despite high demand. It determines which areas of the country are worth investing in, as providers look for an eligible pool of potential employees, and as seen this winter affects the responsiveness of the service to a crisis.

Staffing is important in every care setting, but particularly in home care where provision is linked almost entirely to the number of staff that a provider can employ. (This is true to an extent in nursing and residential care, though there are other factors that limit provision, namely beds and estate space, in those settings.) Interviewees and attendees agreed that without resolving the workforce crisis, it is unlikely that adult social care will be able to provide the level of service that the government and public expect, and which is contributing to problems in the NHS.

One of the main drivers of the crisis is the lack of funding. This means lower fees for providers, who in turn pay their staff less, making roles less attractive. This has been exacerbated by the cost of living crisis and a tight labour market, which have led to other employers in competing industries – most notably the retail and hospitality sectors, and the NHS itself – raising wages and attracting staff away from adult social care.[22] One of the main levers for attracting more social care workers is therefore higher pay. However, this would require commissioners to pay providers higher fees, which would in turn require more funding from central government.

If there was political will to increase funding for the service, there are ways of raising the likelihood that higher fees made their way to carers. The first is the national living wage (NLW). Many care staff are eligible for the NLW and have benefited from the recent rises that the government has introduced. This doesn't, however, necessarily compensate for the relative unattractiveness of the service compared to less stressful jobs in retail or hospitality say, which also pay the NLW or more. The NLW also does not always filter through to care workers; there is some anecdotal evidence that not all care home providers comply with NLW requirements, though this is difficult for local authorities to police as HMRC is the regulator for this issue.[23] The introduction of the NLW, without commensurate funding increases, also made it harder for providers to maintain the pay differential between more and less experienced carers.

A second mechanism for ensuring higher fees reached care workers would be a sector-specific minimum wage, set above the nationwide NLW and designed to improve recruitment and retention in the service. This would be more complicated than raising the NLW as it is likely to require new legislation, but would increase the relative attractiveness of the service compared to other sectors. This, though, would still require more funding for the service, as mandating that providers pay higher wages while providing them with the same level of funding would result in many leaving the market.

Fixing workforce shortages has been made harder by Brexit. The proportion of the adult social care workforce that were EU citizens rose from 4.7% in 2012/13 to a high of 7.5% in 2020/21. In 2021/22, the first full year after the Brexit transition period ended on 31 December 2020, the proportion of the workforce from the EU, fell slightly to 7%.[24] Given the total number of filled posts sat at 1.67 million in 2020/21 and 1.62 million in 2021/22,[25] this implies that the number of people from the EU employed in the social care workforce fell from 125,000 to 113,000 – a 9.5% reduction.

The government has recognised this and taken steps to address the supply shortage by placing care workers, care assistants and home care workers on the shortage occupation list (SOL), which is designed to help recruit workers that are in short supply from outside the UK.[26] There are, however, issues with this. Only those carers who are paid above £20,480 are eligible for a visa, but the average salary for care workers is £17,900,[27] meaning that it is still difficult for providers to employ people from abroad without paying them above market rates.

Instability disincentivises investment

A recurring question throughout the roundtable was how to encourage increased investment in the service, in particular in the nursing and residential sectors. Those sectors are of particular interest because, unlike home care as described above, increased provision requires more beds and estate space as well as more staff. That means upfront capital investment, which providers then use as assets over the following few years.

But investment entails risk for providers. They need to be relatively sure that they will be able to generate a return sufficient to service the cost of borrowing throughout the useful life of the assets. In other words, investment follows stability. This stability comes in the form of financial stability, but also policy stability and macro-economic stability. Unfortunately, there has been limited stability in any of these in recent years.

Some of this is outside the government's control – for example, the macro-economic instability caused by the pandemic – but it can do more to increase financial and policy stability. On the financial side, the current model of funding adult social care is not well suited to generating anything more than short- to medium-term certainty for providers. As previously discussed, much of the funding is used far less efficiently than it could be due to its being allocated on a short-term, emergency basis, or made clear to local authorities only at the last minute.

On policy, the government could try to provide more stability. Charging reforms have been discussed for more than 25 years and legislated for three times without any change happening (even if the most recent model mooted was of questionable value).[28] This policy toing and froing both makes it more difficult for providers to plan and also makes them less trusting of government when they announce another round of reforms.

Local trust can help unlock investment

Good local relationships can facilitate investment even in spite of these various sources of instability. Providers told us that they are more likely to invest in an area where they have a strong relationship with local authorities. In practice, this tends to mean that they know that they will receive business from commissioners and that those local authorities will pay a sustainable rate, making investment worthwhile. For example, a care provider reported that a trusting working relationship with a council meant that they felt sufficiently certain of future business to fully refurbish a care home in the area.

There was a feeling among the local government sector that trust also needs to flow the other way. It is easier for local authorities to make commissioning decisions when they are certain that providers will continue to operate, affording clients and councils a decent amount of stability.

Stability is an intangible and difficult-to-foster factor, but local authorities and providers should do what they can to create this locally – though again it would be easier for local authorities to develop such trust if they had longer-term and higher funding.

Ownership stakes in the care home sector are not attractive to investors

Those we spoke to from the investment sector argued that pensions funds in particular – which, like other 'institutional investors', look for stable returns and have substantial capital to deploy – have little interest in investing in care homes providing publicly funded care, despite the fact that there are many ways they could do so. However, all of these are problematic.

They could, for instance, take an ownership stake in a care home provider that they would then operate.* But local authority fees are not high enough to provide a sufficient margin for pension funds and while self-funders pay higher fees, they tend to be concentrated in certain parts of the country. Demand, and therefore revenue, can also be unpredictable and unstable. When this is combined with already small margins, the business looks risky to investors seeking stable and predictable returns on investments over a long period of time. As currently funded, a good return requires private firms to invest at the right point in cycle, often through consolidation of smaller providers. However, this is too unpredictable and therefore only attractive to more risk-based investors, such as private equity, which looks to compensate for the higher risk with making higher returns through more leverage.

* The option of building and leasing care homes is examined in the next section.

Institutional investors also saw the operational risks of running care homes as unattractive. These include poor care delivery leading to poor inspection results, which could in turn jeopardise the reputation and profitability of the business. We were told that most pension funds do not have the management expertise to operate care homes.

Again the staffing crisis plays a part here. Operating a care home company is made more difficult by the ongoing problems with recruitment and retention. Even when it is possible to hire staff, high turnover means that it is often left to inexperienced staff members to provide care, exacerbating the regulatory risk and so risk to investment.

Owning and leasing care homes is a more likely route for investment in publicly funded care

One area where institutional investors could invest in publicly funded care provision is in the construction of care homes. Many have experience in constructing other commercial and residential property, and so are likely to see less risk involved in new projects.

This would be welcomed by local authorities and people who draw on care as a lot of care home property is old and not fit for purpose; many small operators provide care in buildings such as old vicarages that are poorly equipped, especially for measures such as infection prevention and control that have become more important since the pandemic.

The workable model for them would involve building a large care home in partnership with a local authority. The pension fund would provide the capital, with a guarantee from the local authority that they would then enter into a long-term lease with the fund. This is attractive to pension funds because it aligns with the type of cash flow that pension funds seek; in other words, long-term, stable and above inflation – somewhere in the region of 5–6% (during times of more stable inflation). Pension funds also prefer this model because they see working with the government as very low risk – local authorities are unlikely to go bust and default on their debts.

This could be attractive to local authorities, but would very much depend on the rates at which they could effectively 'borrow' from the private sector. This is because local authorities have the option of borrowing from the Public Works Loan Board (PWLB), which tends to lend at below market rates, though interviewees did point out that this is not always the case.

While new, purpose-built care homes might be more efficient to run, it is probable that placements would still cost more than in older facilities. Currently, low local authority fees may cover a providers' variable costs, but rarely covers all of their fixed capital costs, which can then in effect be cross-subsidised by self-funders. Covering the full fixed capital costs would be more expensive. Local authorities would have to decide whether they were willing and could afford to pay more for better quality provision. Equally, this leasing model is less likely to work for both private sector and not-for-profit providers of publicly funded care home places. Without a guarantee that public sector commissioners could pay sufficiently high rates to cover the lease, the proposition becomes less attractive for pension funds.

Private investment is unevenly distributed across the country

As noted, providers are most likely to invest in areas where there is a high prevalence of self-funders. This means that investment in the care home sector tends to flow towards parts of the country that have a high population of wealthy older people – mostly London and the South East.

Another determinant of investment is the availability of a potential workforce to staff homes. Due to the low wages paid to care staff, this often means that a more deprived working population is attractive to providers. As one interviewee memorably described to us: "Providers are more likely to invest in an area with a rich older population and a poor younger population." Unfortunately, this set of incentives does not align with areas of high demand for social care, meaning that there can be 'care deserts' in some of the more deprived areas of the country – described by attendees as the "posh homes for posh people" phenomenon.

What could government do?

While some factors are evidently outside government's control there is a role that it can play in addressing others. In particular, the government could improve both policy and financial stability for the sector. The delay of charging reforms has benefits and disadvantages, but it certainly makes it harder for local authorities and providers to plan when monumental changes are constantly moved in and out of the realm of probability.

The government could also take steps to increase financial stability in the sector. This could take the form, for example, of longer term local government finance settlements, that match the length of the spending review period (normally three years). Finance settlements could also be delivered at least three months before the end of the financial year, to aid planning.

Most obviously, a sustained funding increase for social care would allow for higher wages (including through a sector-specific national living wage) and thus go a long way to improving the workforce situation, and would make the sector more attractive for private investment. The benefits of this would need to be weighed against the cost of higher taxes, increased borrowing, or cuts elsewhere that would be needed to pay for it. The abolition of the health and social care levy in 2022 shows the political difficulty of raising taxes.

With higher funding, the government could choose to guarantee a minimum level of return for providers in the region of 6–7%. This is below what would be typical for private equity investors, but would be attractive to pension funds. This is similar to the approach taken in Japan. There, central government guarantees a minimum national level of funding, which local government is then able to top up depending on the local context.

Adult social care's role in the wider NHS crisis has been overplayed, but as an important service in its own right it is still performing well below the level that many politicians and members of the public expect.[29] The government has another opportunity to address some of these issues in the spring budget, though there has been no indication that it intends to do so. This paper has explored the reasons for this and why the government's current approach to funding the service is unlikely to resolve the underlying workforce crisis or the lack of capital investment.

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