Written evidence submitted by United Kingdom Homecare Association (WBR0045)

About UKHCA

1. We are a member-led professional association, with over 2,100 homecare provider members across the UK, 1,952 of which are in England. Our members encompass the diversity of providers in the market: from small to large; predominantly state-funded to predominantly private-pay funded; generalist to specialist; and from start-ups to mature businesses. Our purpose is to enable a strong, sustainable, innovative and person-led homecare sector to flourish, representing and supporting members so that people can live well and independently at home.

2. Over 4.1 million hours of state-funded homecare are purchased each week in the UK. This enables over 850,000 people to be supported to live at home independently each year. The size of the privately purchased homecare market is not known with certainty, but may represent a further 1.75 million hours and 364,000 people.

How resilient was the NHS and social care workforce under pre-COVID-19 operating conditions, and how might that resilience be strengthened in the future?

3. Overall we believe that the homecare workforce has been remarkably resilient during the coronavirus pandemic, and we pay credit to the work of so many people in exceptionally difficult circumstances. A considerable amount of this has come from the dedication and professionalism of staff who have worked above and beyond their contractual requirements in an emergency situation. This resilience, however, is unlikely to be indefinite, and must not be considered a long-term position.

4. As UKHCA has said in a previous submission to the Health and Social Care Select Committee, people want to live well and independently at home. Preventing unnecessary admissions to care homes and hospitals, where there is currently an increased risk of COVID-19 infection and death, should be a priority. Supporting people at home, as far as possible, is an intelligent and cost-effective strategy for the nation's health and well-being.

5. The resilience of the homecare workforce prior to the Covid-19 pandemic was of great concern. UKHCA members have told us that recruitment and retention of careworkers with the right values and disposition was (and remains) the highest risk to the ability of homecare providers to continue providing their service. The fees paid to homecare providers, by councils and the NHS, which in some cases do not cover the cost of paying the statutory requirements of the National Minimum Wage and pensions contributions, have the biggest impact on recruitment and retention of the workforce, and the overall financial viability of the homecare sector.

6. Other factors, such as councils purchasing care by the minute, which leads to careworkers being paid by the minute and monitored on time spent with people, rather than focusing on meeting needs and improving outcomes, results in employee dissatisfaction and high turnover.

7. The staff turnover rate was higher for domiciliary care providers in 2018/2019 than other service types within social care. Over a third (38.8 per cent) left their role within the previous 12

months which equates to an estimated 190,000 workers. Care workers had a turnover rate of 44.3 per cent, which equates to an estimated 166,000 leavers.[1]

8. Pre Covid-19, the homecare sector was already fragile and continues to be undermined by below cost fees being paid by the NHS and local authorities, UKHCA has calculated the "Minimum Price for Homecare" for 2020/21 at £20.69 per hour, which includes the increase in the National Minimum Wage and National Living Wage from 1 April 2020 which include their travel time, mileage and wage-related on-costs. The rate also includes the minimum contribution towards the costs of running a care business at a financially sustainable level.

9. Our data on 131 out of 152 local authorities, collected up to 7 April 2020, shows that the median fee rate for homecare being paid by councils was only £16.96 per hour. Indeed, only 1 in 7 councils and a minority of CCGs are paying at least the UKHCA's Minimum Price for Homecare.

10. An independent analysis of provider costs, commissioned by UKHCA, estimates that costs due to COVID-19 have increased by nearly 25 percent against the median fee rate. The extra costs equate to an estimated additional £3.95 per hour of homecare.

11. Strengthening the resilience of social care staff will largely depend on finding a long-term funding solution for social care. UKHCA has welcomed the Social Care Taskforce, whose final report to Government had not been published at the time of writing. A number of recommendations about the social care workforce have been made by the advisory group appointed to assist the Taskforce. We do not know whether they have been accepted. There has also been an apparent demarcation between the work of the Taskforce (essentially short-term, with a focus on Covid-19 and winter pressures) and more structural issues of longer-term reform of the social care system. In the current economic climate, we are concerned that social care may not receive the funding it needs to become a truly resilient service.

What has the impact of the COVID-19 pandemic been on resilience, levels of workforce stress, and burnout across the NHS and social care sectors?

12. UKHCA has had regular contact with members from the start of the pandemic. In the early stages there were reports of increased absence - up to 15% of staff in some cases, due to staff shielding or self-isolating and which meant the remaining staff working long hours to provide cover for those who were absent. Overall, however, absenteeism in the homecare sector settled considerably to around the levels experienced in pre-covid period Recruiting additional staff is not an option for short-term cover due the induction and safety training required before a person can start delivering care.

13. The lack of PPE, lack of access to testing and confusing and conflicting guidance from the government and its agencies has significantly affected stress levels amongst carers, office staff and managers. Our membership, without exception, has reported excessive time spent trying to source the correct PPE to comply with guidance; one member calling the UKHCA helpline reported that she had spent an entire two days trying to source PPE but could not find a supplier

[1] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/Summary-of-domiciliary-care-services-2019.pdf

with any stock. A number of businesses which cover two or more of the UK nations has reported their frustration at having to deal with the different guidance for each devolved nation.

14. Deaths of careworkers (and indeed NHS staff) have no doubt increased the stress of homecare staff. The ONS have reported the number of deaths from Covid-19 of social care workers, including homecare workers as 312 between 9 March and 20 July 2020.[2] We are confident that homecare workers will have been aware of the risks of contracting Covid-19 which will have added to their stress levels. A study by the ONS shows that those working in patient-facing healthcare or resident-facing social care roles are more likely to have been infected by COVID-19 over the study period than those not working in these roles. This includes NHS professionals, such as nurses and doctors, as well as social care workers, such as nursing home or home care workers and social workers.[3] The prevalence survey of transmission rates of COVID-19, published in July 2020, has subsequently provided some reassurance that the transmission rates of coronavirus amongst homecare workers mirrors the general population.[4]

15. Staff and service users were highly stressed in the early weeks of the pandemic about the advice on wearing of masks. Members of the Committee will have seen the report from the Healthcare Safety Investigation Branch (HSIB)[5], 'Personal protective equipment (PPE): care workers delivering homecare during the COVID-19 response' which highlights a case in April where a care worker visited the home of a 'clinically extremely vulnerable' person and did not wear PPE. The person later died from coronavirus and showed no symptoms of the virus when the care visits took place.

16. In response to the report, Jane Townson, chief executive of the United Kingdom Homecare Association, said: "The production of official guidance on personal protective equipment has been a shambles throughout the coronavirus pandemic. Guidance designed for different care settings has been consistently confusing for the organisations who needed to put it into practice.

17. "In the early stages, an absence of clarity led to inconsistent local interpretations being made by public health, local councils and community health organisations, all with different views about what was required."

18. Live-in care services (where a careworker resides in a service users' home for an extended period of time) experienced the early lockdown period of the pandemic differently from those services which send careworkers into a person's home on a daily basis. Live-in careworkers experienced relatively less stress as they were locked down with their clients, but some careworkers from abroad felt the stress of being unable to travel to their home countries due to

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2 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/adhocs/12112deathsinvolvingthecoronaviruscovid19amonghealthandsocialcareworkersinenglandandwalesdeathsregisteredbetween9marchand20july2020

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4 https://www.gov.uk/government/publications/covid-19-prevalence-survey-domiciliary-care-staff-in-england

5 https://www.hsib.org.uk/documents/240/PPE_care_workers_delivering_homecare_during_the_Covid-19_response.pdf

travel restrictions. Now the economy is opening up, some live-in careworkers who are not British Nationals are planning to return to their country of origin. There are concerns from this part of the homecare sector that the supply of overseas workers (for whom live-in care is particularly attractive) will be severely affected at the end of the transition period from the European Union.

What is the current scale of workforce burnout across NHS and social care? How does it manifest, how is it assessed, and what are its causes and contributing factors? To what extent are NHS and care staff able to balance their working and personal lives?

19. While UKHCA data is not available, our members are concerned that staff are already exhausted, and that they expect to see burnout and stress levels increase over the coming period. Homecare workers, office staff and managers have 'risen to the task' and worked over and above their normal hours to make sure that care is provided at home to people who need it. This is not sustainable over the longer term and there are significant worries about the winter pressures coinciding with a second wave of Covid-19.

20. Stress and burnout is manifested by careworkers needing additional time away from work, which in turn places more stress on who have to supply cover. Turnover rates in homecare are already high (see paragraph 6), but there is no data on whether turnover has increased over the period of highest transmission of the virus.

21. We have a concern that policy makers are assuming that higher levels of unemployment as a result of the closure of other business sectors will create a sense that recruitment to social care will become easier, without giving regard to the loss of knowledge and experience of staff who have burned-out or the difficulty of substituting newly recruited workers from other sectors.

What are the impacts of workforce burnout on service delivery, staff, patients and service users across the NHS and social care sectors?

22. UKHCA members have told us that many families have withdrawn from packages of care during the lockdown period, being concerned that the person receiving care could contract the virus. This was more evident in the early stage of the pandemic, and there must be concerns about whether family carers were able to provide the appropriate level care for their loved one. UKHCA members reported in April 2020 that decisions to withdraw from the care package was based on choice rather than availability of staff and driven by clients' demands for careworkers to use of face masks. The numbers of withdrawals ranged from 4.6%, to 15% of service users.

23. Also of concern to UKHCA was the withdrawal, in some areas of the country, of the district nursing service which meant that careworkers were taking on some of the tasks of medical professionals such as wound care. Again, data is not available, but UKHCA are worried about the health implications for service users when district nurses are unwilling to carry out home visits.

24. Our impression is that members of our workforce have found increased roles fulfilling and have an appetite to do more. We should recognise that in many cases these role changes have been through necessity. Expanding roles for the workforce in normal times should be a planned activity, backed-up with the appropriate level of training and oversight.

What long term projections for the future health and social care workforce are available, and how many more staff are required so that burnout and pressure on the frontline are reduced? To what extent are staff establishments in line with current and future resilience requirements?

25. UKHCA have described the extent of the shortage of careworkers in our evidence for the committee's inquiry into Funding and Workforce. We reproduced that evidence below for convenience.

26. Vacancies in social care will become a greater problem as the demographics of those receiving homecare change. The Office for National Statistics calculates that the number of people aged over 65 will increase by 20.4 per cent over the next 20 years, while the proportion aged 85 years and over is projected to almost double over the next 25 years.[6]

27. Skills for Care's data modelling suggests that the number of social care jobs (across all sectors) will need to increase by between 32 per cent (520,000 jobs), to a total of 2.17 million by 2035.[7] Following a trend in government policy to support more people at home, increasingly higher proportions of this workforce growth will be in the homecare sector. Indeed, Skills for Care data show there are now more jobs in homecare (715,000) than in care homes (680,000) or other parts of the sector.

28. Currently there are 122,000 vacancies in the social care workforce; the modelling and demographic changes referred to above suggest that over the next five years, many more homecare workers will be needed. Professor Brian Bell, Chair of the Migration Advisory Committee has been reported as saying that, "problems [of recruitment] in the social care sector must be fixed by 'properly funding' it, not 'fiddling about with immigration'." However, without a long-term funding settlement for social care providing for higher pay rates for care workers, the recruitment and retention problem will likely worsen, especially when the new points-based immigration system is introduced from January 2021.

29. Although there is the prospect of an increased number of applicants available as unemployment rises as a result in contraction of other business sectors during the coronavirus pandemic, enhancing pay for careworkers will not necessarily offer sufficient candidates of the right calibre. Working in homecare requires the right values, ethics and disposition to be successful and in order to provide highly intimate care for people with complex health and social care needs such as dementia; those with a complex medication regime; or require management of a tracheostomy, stoma or catheter. Human interaction with empathy, sensitivity and emotional intelligence is needed to successfully communicate with people with one or more sensory loss; with people who cannot speak; or with people who need assistance with weight bearing or transfer (from bed to commode for example).

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[6] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2018based#changing-age-structure

[7] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-size-and-structure-of-the-adult-social-care-sector-and-workforce-in-England.aspx

30. UKHCA therefore considers the homecare workforce needs urgent investment in order to develop the resilience needed for the short and longer term.

To what extent are there sufficient numbers of NHS and social care professionals in training for service and resilience planning? On what basis are decisions made about the supply and demand for professionals in training?

31. UKHCA does not have information on numbers of social care professionals in training. However, Skills for Care report that regulated professions accounted for 5% of social care jobs and include social workers, occupational therapists, registered nurses, safeguarding and review officers and allied health professionals.[8] As the numbers of people needing care at home increases, there will be a need for more professionals, especially those with specialist skills, such as in dementia, skin care, continence and nutrition.

Will the measures announced in the People Plan so far be enough to increase resilience, improve working life and productivity, and reduce the risk of workforce burnout across the NHS, both now and in the future?

32. UKHCA is disappointed government has not developed a workforce plan for social care to sit alongside the NHS People Plan 2020/21.[9]

33. As we have previously said to the committee, the ability of social care employers to recruit and retain staff has been exacerbated by the widening pay differentials between healthcare assistants employed in the NHS, and the pay of homecare workers in the independent and voluntary sectors.

34. From April 2020, an NHS healthcare assistant in Band 1 can expect to receive £9.21 per hour whereas careworkers receive, on average the National Minimum Rate of £8.72 per hour. In addition to the comparison of pay rates, above, NHS employees generally receive more advantageous pension and annual leave entitlements than are available in the independent and voluntary homecare sectors.

35. What must be borne in mind is that the NHS and social care employers are trying to recruit from the same pool of employees, a pool which will shrink further from 1st January 2021 when the new points based immigration system is introduced cutting off non-UK applicants workers from applying for roles as careworkers. UKHCA continue to argue that careworkers should be accepted on the shortage occupation list.

36. UKHCA is calling for the Government to develop a workforce plan for social care which will address the underlying problems of recruiting and retaining staff in the homecare sector. The workforce plan will need to sit alongside the long awaited funding settlement for social care.

37. That settlement should mandate that commissioners of homecare within local councils and the NHS should be obliged to pay fee rates that allow for a sustainable and vibrant homecare sector

[8] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2020.pdf

[9] https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

which can invest in training, innovate with new technology and develop a more personalised approach to care in partnership with NHS community services.

38. UKHCA have argued previously that what is needed is a mandated, fully funded, and ring-fenced, national minimum rate for homecare, calculated using the UKHCA's evidence-based model, which enables: a) careworkers to be recognised with terms and conditions on a par with equivalent skills and experience in the NHS; and b) providers to deliver high quality care, meeting or exceeding regulatory requirements.

What further measures will be required to tackle and mitigate the causes of workforce stress and burnout, and what should be put in place to achieve parity for the social care workforce?

39. UKHCA has set out the following in our evidence to the committee on Funding and Workforce. Again, for convenience, that evidence is reproduced below.

40. UKHCA believes that tackling and mitigating workforce stress and burnout will only be successful if the systemic problems in social care are addressed. We want to see:

    - development of accredited and portable training;
    - development of a clear career pathway within an integrated workforce plan;
    - registration and professionalisation of the social care workforce in England.

41. The social care funding system needs to invest in prevention and rehabilitation services which homecare services are perfectly placed to deliver. People aged over 60 are the most likely to have hip replacements; 35 per cent of all hip replacements are carried out on those aged 70-79. People aged 80+ are most likely to attend A&E, and one in three emergency patients admitted for an overnight stay had five or more health conditions. Well-structured homecare packages that focus on outcomes can help prevent avoidable hospital admissions not only for falls but also for malnutrition which has increased fivefold over the last decade. Engagement with homecare providers to deliver care for people to maintain or regain independence will improve the service overall and reduce rates of hospital admission and readmission.

42. Social care funding should be sufficient to allow for a minimum of 30 minutes, and preferably 1 hour, for homecare visits. Despite statutory guidance saying short home-care visits of 15 minutes or less are not appropriate for people who need support with intimate care needs,[10] and guidance from NICE,[11] local authorities continue to commission homecare visits of 15 minutes.

43. Allowing sufficient funding for social are should be tied to reform of commissioning practice, particularly prohibiting 'payment by the minute' whereby providers are only paid for each minute the careworker is in attendance. Dr Jane Townson, UKHCA's Chief Executive Officer, has already given verbal evidence to the Committee about this practice which does not compensate

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[10] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[11] https://www.nice.org.uk/guidance/ng21/chapter/Recommendations

providers for travel time, travel expenses, breaks, sick pay, training and so on, costs which the provider must still meet.

44. Delivering improved homecare services will require significant investment to speed-up the implementation of digital technology to improve the efficiency and quality of homecare services, and to support people to live well and independently at home where technology could replace personal care.

45. A proportion of funding should be directed towards research and data collection which will assist on developing new models of care, and provide evidence for which models of social care can provide the best outcomes for individuals and as part of a system of health and social care. For example, live-in care is an option for many people which is not widely funded by councils. However, live-in care can be a viable alternative to admission to a care home while maintaining a person's independence in their home and community.

46. Future reforms should provide for oversight by an independent body of how local authorities meet their market-shaping duties. The Care Act 2014 placed a market shaping duty on councils in England but there is no systematic view of whether these responsibilities are being discharge. Nor is there oversight of commissioning practice which is fundamental to ensuring people receive the services best suited to meet their needs.

47. There should also be a reform of VAT. At present, the VAT status of regulated homecare is "exempt" from VAT.[12] This means that the end-users of regulated care (councils, the NHS or private individuals) are not charged VAT, but regulated providers are unable to re-claim the VAT which they pay on the products and services they purchase in order to deliver that care. Government should change the VAT status of "welfare services" from "exempt" to "zero-rated", so that homecare providers can re-claim their input taxes.

48. Funding reform should include a review of the fees homecare providers pay to the Care Quality Commission - recent increases have unfairly impacted on the homecare sector. UKHCA members generally support registration and inspection and recognise that there is a cost to regulating adult social care. However, in April 2018, the Care Quality Commission (CQC) introduced a new method of calculating annual registration fees which had a far greater impact on homecare providers than other sectors.

49. If providers are to bear the costs of regulation, then it is imperative that CQC demonstrates value for money in its regulatory activities and is confident that its fee regime does not exacerbate financial pressures within the sector.

50. The greatest impact of the fee changes has been on larger providers who have seen some fees increase by between 100 per cent and 1,000 per cent, though some very small providers, with 50 or fewer service users, will have seen more modest increases or, in some cases a reduction in fees over what was paid in 2017.

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[12] HM Government (2011) Welfare services and goods (Notice 701/2). See: www.gov.uk/guidance/welfare-services-and-goods-notice-7012.

51. Until there is a vaccine, Covid-19 will continue to add additional costs to homecare employers, particularly for PPE and sick pay. Funding reform should include payment for PPE and full pay for employees who have to self-isolate because of having or living with someone with Covid-19 symptoms. That will help protect people receiving homecare and ensure careworkers will stay at home when they have, or may have been in contact with the virus.
52. Finally, a further reform UKHCA would like to see is homecare providers being made exempt from business rates to create parity with care homes, which are not required to pay business rates.

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