Written evidence submitted by Community Integrated Care (ASC0062)

Community Integrated Care Submission to the DHSC Select Committee Inquiry on Inaction in Social Care Reform

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Introduction

This is a submission by Community Integrated Care to the DHSC Select Committee Inquiry on the impact of inaction on social care reform. Community Integrated Care is a large social care charity that provides services to support working age adults with a wide range of support needs including learning disabilities, mental health concerns, autism and dementia, and has an annual financial turnover of £170m. We employ over 6,400 colleagues to deliver over 8 million hours of care and support every year, through over 500 services across England and Scotland - supporting over 2,500 people to live full and independent lives. Nearly all of the people we support are eligible for publicly funded services, so our income is derived entirely from local government through the fees in our contracts with local authorities.

This submission is not comprehensive and is shaped in response to the overall question posed by the Select Committee. We identify the impact of previous inaction to reform the social care system including health inequalities among people with learning disabilities; the low pay of the care workforce, the financial sustainability of care provider organisations; the performance of the NHS which relies on social care for its success; and the missed opportunity for economic growth. We make a series of suggestions for action to be taken in the future to improve the social care system, particularly with regard to the needs of adults with learning disabilities.

The issue of how social care services should be funded and who is eligible for publicly funded care is not addressed in this submission. We hope that this fundamental question will be addressed by the government through a rapid review by an independent, cross-sector and cross-party commission that will make recommendations for change to be implemented in the lifetime of this Parliament.

1 The impact of inaction to reform social care

The impact of previous inaction to reform social care has fallen upon those who draw upon care and support, NHS patients, unpaid carers, social care providers, local government, NHS providers (hospitals, primary care, and community health services) and social care providers. It has also had a direct impact on the growth of the economy, particular in low-income areas of the country.

a) Health inequalities among adults with a learning disability

Previous inaction on social care reform has contributed to the continuing health inequalities experienced by adults with learning disabilities. The health and mortality rates show that people with learning disabilities die younger than their equivalents in the general population with similar health conditions. This population group will grow in size as people with learning disabilities are living longer than before yet they experience significant inequalities in the time spent waiting for a diagnosis and in accessing routine healthcare and health checks. On average, women with a learning disability die **23 years younger** than women in the general population; and men with a learning disability die **20 years younger** than men in the general population. 38% of people with a learning disability died from an avoidable cause, compared to 9% in a comparison population of people without a learning disability

b) Unfair pay and no workforce strategy

Previous inaction to reform social care has contributed to the prevalence of low pay in the care sector which has had a significant impact on the social care system. A series of 'Unfair to Care' reports published by Community Integrated Care describes the key workforce challenges facing the social care system resulting largely from low pay including high turnover of staff and low retention

rates, high staff vacancies in social care services, over-reliance on expensive agency staff, and high training costs for the high number of new staff being recruited. Most care workers are paid only the National Living Wage in a highly competitive labour market. Our research shows that the size and complexity of a care worker's job is equivalent to that of NHS Band 3 staff. Yet, the average take-home 'total pay' salary of equivalent NHS Band 3 staff is 36% higher than that of the average salary of a frontline care worker.

Our research is confirmed by the Skills for Care Annual State of Care Workforce report that illustrates how previous inaction on social care pay has an impact on the social care workforce, the efficiency of social care providers, and the system as a whole.

Importantly, previous inaction to reform the social care workforce is not just about pay and conditions. There is currently no government funded national social care workforce strategy to match the NHS Agenda for change or long-term workforce plan for staff in the NHS. Consequently, there is no recognised career path structure, no recognised associated suite of care qualifications, and no registration scheme for care workers or care managers. Nor is there any government estimate of the changing social care workforce needs in different care sectors and how these will be met in future.

c) Underfunding, and out of date commissioning and funding mechanisms

Previous inaction on social care reform means there is not enough public funding of social care services to meet the current or growing need for social care. This means that people with low-level care needs are not able to access publicly funded social care services that would help prevent their potential decline in their health and wellbeing. This lack of funding also means that services for those with higher level needs are often of lower quality than they require to achieve the system's goals of enabling people to live full, healthy and independent lives. The Autumn Budget 2024 has greatly exacerbated this problem by imposing significant additional unfunded costs on care providers through increased ENICs and the higher NLW that the president of the Association of Directors of Adult Social Services described as having 'catastrophic impacts on the cost of adult social care – not just for local government, but also for our important partners who support people in their neighbourhoods and places in our voluntary and community sector'.

The lack of resource in the whole system leads to short-termism in care commissioning by local authorities. Too much time is spent on re-negotiating contracts and re-modelling services to fit changing commissioner criteria focused on price rather than improving service quality and outcomes.

Previous inaction to reform social care has led to social care commissioning being dominated by concerns about single metrics related to cost and price, rather than improving quality of life outcomes, reducing health inequalities or ensuring services are tailored meet individual needs. Commissioning frameworks are often inflexible and provide little incentive for innovation. This focus on price alone can create a 'race to the bottom' in the quality of care as contracts are awarded only to the cheapest providers, and leaves little scope for improvements in productivity and effectiveness.

d) Poor NHS performance

The NHS and social care systems both face mounting pressures from rising demand, resource limitations, and persistent health inequalities; and each is highly dependent for its success on the performance of the other. Professor Lord Ara Darzi was right to say that 'it is impossible to

understand what has been happening in the NHS without understanding what has happened to social care'.

The NHS relies upon social care to achieve key targets and outcomes such as preventing the deterioration of people's health and wellbeing; reducing unnecessary demand for primary and community care; relieving pressure on hospitals for unnecessary emergency and acute care; and reducing delayed transfers of care. Social care, in turn, relies upon the NHS to provide effective and timely clinical care and support in order for them to achieve their objectives of enabling people they support to live full, independent and healthy lives.

Previous inaction on social care reform means that achieving the three shifts in care by the (from hospitals to community, from treatment to prevention and from analogue to digital) will be made impossible. Reform of hospitals to deal with rising demand from avoidable admissions or delayed transfers of care will be unsuccessful unless and until action is taken to stabilise, strengthen and expand social care. Ensuring a robust social care system is a pre-requisite for fixing the NHS both in delivering better acute care, and providing effective primary care and community health services.

Integrated Care Boards are the centres of power and resources in local health and social care systems but their board membership does not reflect the interdependency of the NHS and the social care systems, and in their current form are not fit for purposes of delivering the three shifts in care that are the priority for the government and the NHS. The financial demands of the acute sector in the NHS dominate decisions and priorities about the allocation of NHS budgets to the detriment of investment in community-based services, preventing ill-health and building a better social care system. The needs of social care providers are entirely overlooked by ICBs.

e) Missed opportunity for economic growth

The adult social sector is a large part of the economy and a major driver of economic growth with over a million service users, a 1.5 million workforce (bigger than the NHS), a £60 billion industry (bigger than the oil industry,) and over 18,000 independent provider organisations. Consequently, previous inaction to reform and improve the social care system has been a missed opportunity to have a major economic impact on the lives of millions of people, on communities in very part of the country, and on the economy as whole.

2 Action for change

Previous inaction on reform inherited by the current government should be taken as an opportunity for the government to take rapid and robust action for change. Whilst it will take time and resources to address the many challenges in social care there is much that can be done within limited resources that would nonetheless make a significant impact.

a) Reduce health inequalities of people with learning disabilities

Action to eliminate the health inequalities among people with learning disabilities is required to improve their care in hospital, provide integrated care in community settings, prevent people becoming unwell or experiencing a decline, and use of digital ways of working in a blended model of digitally-enabled care. Specific suggestions for action include:

Health checks and action plans: Health inequalities could be reduced substantially, and a shift from treatment to prevention delivered, if some basic and straightforward actions were taken to provide

health and checks to people with learning disabilities, create people-centred holistic health action plans that address the causes of ill-health, and monitor those plans to ensure they are implemented in a standard system of continuous service improvement. Measuring progress on reducing and eliminating these health inequalities requires the use of a few key performance metrics including output measures such as the proportion of adults with learning disabilities having a health check and an action plan, and delays in access to health services including dentistry; and outcome measures such as comparable mortality rates, levels of obesity and diabetes, and quality of life measures such as exercise and connectedness to community activities and facilities.

Services that reach out to people: The process of undertaking health checks that leads to action plans must be meaningful and engaging for the individual, and reflect their personal conditions, culture, community and circumstances. This will require innovative ways of reaching out to people by services whose ways of working make it harder for people to access or engage with. Social care organisations and community groups have a key role to play in advising health organisations on how to do this.

From residential to community care: There is often a lack of understanding in the NHS about the complex needs of people with learning disabilities and how to meet them. Many do not need to be held in secure residential accommodation but, with the right skills and the right environment and the right funding, could be supported to live in the community. A risk stratification approach could be used to identify people who might benefit from a specific budget aimed at meeting their needs, move them from residential care and ensure the system responds to those needs with appropriate high intensity support in the community.

Neighbourhood health and social care service: The proposed development of a new model of a 'Neighbourhood NHS' opens up many potential benefits for people with learning disabilities and/or autism. They have a variety of needs that the neighbourhood approach could address including physical and mental health conditions, social care support needs, family support, housing, transport, leisure activities and wider connectedness to their local community. To be effective the neighbourhood model should include within its scope the integration of different services within the NHS, between the NHS and social care, and with other key public services that affects the health and wellbeing of people with learning disabilities (e.g., housing, transport and leisure facilities). This would in effect be a Neighbourhood Health and Social Care Service that would help to ensure that decisions about a person's health care and their social care support are made as close to the individual as possible.

Mental health support: Mental health concerns are often unrecognised or overlooked, and frequently co-occur with physical health issues. There is a need for holistic support that addresses both aspects simultaneously. Often physical health conditions take prevalence over people with learning disabilities who have mental health challenges.

Involvement of people with learning disabilities: Ensuring the voices of people with learning disabilities are actively considered in their health and wellbeing planning is crucial. Building awareness and capacity empowers people we support to advocate for their health needs.

Health education and prevention: More focus on preventative health education is needed for people with learning disabilities and their families, with an emphasis on health literacy around diet, exercise, and self-care. NHS and social care staff require the training and resources to better monitor changes in the health of people with learning disabilities so that they can recognise degradation.

Lifestyle and social determinants: Isolation, inactivity, and sensory overload are significant lifestyle factors impacting health. Care plans should more fully address these through daily routines and structured activities.

Collaborative partnerships: Stronger partnerships with GPs, mental health services, and other community healthcare providers are needed to improve early identification and support. Current partnerships are inconsistent, and there are gaps that impact the quality of care particularly in annual health checks and approaches to integrated personal electronic care records (health or hospital passports).

Delegating healthcare tasks: NHS and other healthcare professionals should recognise the limitations of social care staff in performing certain healthcare tasks, acknowledging where additional support or training is needed. Care staff should feel confident to communicate if they are not suitably trained for specific health tasks or assessments.

NHS staff training: NHS staff need to develop better skills for working with and communicating with people with learning disabilities. Some nurses are trained for this but it should be part of all training for healthcare professionals to improve communication and care delivery, particularly for staff in hospitals.

b) Improve care pay and workforce structure

Fair pay: Stability in the social care workforce could be significantly enhanced by providing government funding to share the cost of improving the pay and conditions of care and support workers, and over time work towards pay parity with their equivalent staff in the NHS (Band 3). The case for this and the benefits it would bring to those who provide and receive care and support, the productivity gains for social care and NHS organisations, and the economic growth it supports are fully described in the 2024 Unfair to Care report 'Who Cares Wins'. The proposals to create legally-binding Fair Pay Agreement through the measures and structures in the 2024 Employment Rights Bill are very welcome. However, the increased costs of paying fair wages to care workers that provide publicly-funded care services must be met at least in part by the government through improved funding and commissioning mechanisms.

Interim pay uplift: In the meantime, the Government should provide funding to offset the increased wage costs for care providers in the Autumn Budget 2024, and go further to award a fully funded interim uplift to the hourly pay of care and support workers above the National Living Wage. This would both reward staff for the work they do, improve the productivity of social care providers by enabling care providers to attract people into the social care workforce, fill service vacancies to benefit the NHS, and reduce the cost of high turnover rates in a highly competitive labour market place.

Workforce strategy: Improving pay and conditions is necessary but not sufficient to bring about the step-change needed to create a strong and effective social care workforce. The Government should develop an integrated health and social care workforce development strategy to address the wider social care workforce challenges. This could be done very rapidly by adopting and amending the existing social care workforce strategy already developed by the Skills for Care.

c) Improve care commissioning and funding mechanisms

A quality care market: The current approach to the commissioning of social care must be replaced with a process that begins with social care commissioners adopting the goal of creating a local market of high-quality care providers. This requires the government, as well as local government, to

take a market-shaping role if it wants to see social care providers deliver services that give better outcomes for service users, better experiences and outcomes of care and support for service users, more sustainable and innovative care provider organisations and better integration with the NHS (joint ways of working, joint commissioning, digitally enabled care, shared care records and shared care outcomes).

This approach would move away from commissioning based on 'payment by activity' but on commissioning services using price, volume and quality criteria in a market place of high-quality providers that have demonstrated they can respond to people with varying complexities of level and type of need. This would also accelerate the shift from use of higher cost residential (semi-secure) settings for adults with complex need, to lower-cost and more effective community care settings.

Invest in commissioning: Given the current challenge of social commissioning capability and capacity in local government (similar to the challenge of lack of planners in the housing system), government should invest in developing and recruiting the knowledge, skills and experience of social care commissioners to re-shaping the capacity and quality of social care commissioning.

Cross-service commissioning: For people with complex needs, care commissioning should develop joint health and social care pathways for adults with learning disabilities who have complex physical health, mental health and social care needs. Further than this, would be to develop an integrated cross-service task between the NHS and local government as a whole and embrace commissioning of wider services for people with learning disabilities that seeks to improve the quality of people's homes, their access to transport, local air quality and the availability of community facilities.

Lessons from Covid: Commissioners should implement the lessons learnt from the culture adopted during the Covid pandemic in which the emphasise was on getting things done, and in which commissioners asked providers 'how can we help you to make this happen?'. Arguably, this approach led to one of the biggest ever periods of innovation in the NHS.

d) Better use of digital ways of working

Digitally-enabled care: Social care providers have developed a range of digital ways of working that have been shown to improve people's health and wellbeing and prevent their health decline or deterioration. Social care and health information gathered through digital sensors and monitoring methods can empower individuals to monitor their own health and support needs on both clinical conditions such as diabetes or healthy behaviours such as exercise and diet. These might extend further into information relating to mental health such as social interactions, and contacts with family members. This blended model of social care that combines human contact and support with digital technology services has many advantages for service users and patients, and for health and social care providers and commissioners.

Electronic care records: Electronic care records or a digital health passport should include not only clinical data and health information but also details of the person's social care needs, the support being provided, and their personal preferences and family contacts. A holistic electronic care record that is appropriately accessible by staff within all parts of the health and social care system will be a key tool for preventing avoidable hospital admissions, reducing delayed transfers of care from hospital, and creating 'virtual wards' at the 'front' and the 'back door' of hospitals.

Data and technology: The use of data and technology (e.g., digital records, and health monitoring tools) could be improved to better monitor health trends and flag issues early. Enhanced data use would support the health inequalities strategy, facilitate root cause analysis, and foster trust through

listening to people we support. Research pathways between social care for working age adults and the NHS could be developed to better understand the healthcare needs and experiences of people with learning disabilities. The content of integrated personal electronic care records that reflect the different NHS (medical) and social care (social) models of care, are fundamental to creating a cross-sector digital information data set for use in different ways by service commissioners and providers. Pooling the digital data on the health and wellbeing of service users from a wide range of social care providers would provide valuable information to support service planning and development for both NHS and local authority commissioners of health care and social care support. To do this requires a common code data structure to be developed between the NHS and social care as this currently does not exist.

Standardisation and interoperability: It will be important to have clear standards for the nature of integrated personalised electronic care records to ensure their content reflects best practice, and to ensure interoperability between different digital systems to support better care coordination and reduce hospital admissions and delayed transfers of care. It would be helpful to establish common standards for digital records and coding to enable data sharing across sectors.

Funding: Whilst the Adult Social Care Digital Transformation Fund has been a success, it now needs wider roll out to support widespread adoption of technology-enabled health and social care, integrated personal electronic care records and population-based service planning for people with learning disabilities. Use genuinely pooled budgets for digitally-enabled care to align action across both health and social care providers. Invest in training to equip staff with the skills needed for delivering digitally-enabled care.

e) Fix social care to fix the NHS

Ensuring a robust social care system is a pre-requisite for fixing the NHS both in delivering better acute care, and providing effective primary care and community health services. The NHS and social care system are deeply interdependent, so government action is needed to support the building of strong and sustainable social care services; and for working towards greater integration of the two systems to provide seamless services for people with learning disabilities who have physical health, mental health, or social care needs.

Deliver the three shifts in both health and social care: The three shifts in health underpinning the changes announced by the Government to be made to the NHS apply equally to the reforms needed in the social care system and should be a joint endeavour if they are to be achieved:

- *Hospital to community:* A shift from supporting people in acute or Assessment and Treatment Unit (ATU) settings to supporting people living in their own homes or closer to home is essential to the quality and sustainability of the social care system to support people of all ages and conditions to live full, independent and healthy lives.

- *Treatment to prevention*: A shift in social care from a model that is about 'caring' for people to one that actively supports and empowers people to have more control and 'agency' to live the life **they** want to live, echoes the shift from treatment to prevention in the NHS in which patients are empowered to take action to live healthier lives.

- *Analogue to digital*: A shift from analogue to digital ways of working is already underway in social care, but is not sufficiently recognised. It includes delivery of a variety of 'blended' models of care with practical applications that support people's lives, in personalised and holistic electronic care records and in valuable digital population data that could be shared

appropriately with the NHS to enable the shift in care from hospitals to community and from treatment to prevention.

Improve the joint governance of social care and health: The membership of key decision-making structures in the system such as ICBs should change to reflect the wider role of the NHS in supporting people's health with a better balance of representation between hospital providers and community health and social care providers and commissioners. Specifically, there should be a representative of local social care providers on the ICB to ensure that social care has a visible presence and a strong voice in decisions that are made including the allocation of resources to support integrated digital ways of working across health and social care.

Reform money flows in the system: The unhelpful mix of funding systems (per capita, block contracts, and activity funding) is a major barrier for delivering integrated, person-centred care, shifting resources from hospitals to community and moving from treatment to prevention. Changes to the financial system are required that enable:

- genuinely pooled budgets to support shared goals between the NHS and social care services
- payment structures with shared incentives based on outcomes not outputs
- funding for joint care pathways between health and social care for specified groups such as people at high risk of a hospital admission, people with complex needs including many people with learning disabilities or particular conditions that have an impact across both systems (e.g., dementia)

National targets: National NHS targets on key services affecting adults with learning disabilities/autism such as annual health checks and action plans have not proven to be an effective mechanism to ensure action is taken on the ground. A devolved approach within a national framework and a clear evidence-base would enable local decision-makers to base their actions on best-practice and set local targets based on local population demographics.

However, it will be important to ensure that, when taken at a neighbourhood level through the proposal to establish a Neighbourhood NHS, the local analysis and action does not overlook the potentially smaller numbers of individuals involved for population groups such as people with a learning disability. Strong local accountability for decisions and actions is key to the success of a devolved approach - the right performance metrics are the 'currency' of accountability among local partners in the system. A Neighbourhood Commissioning function (within a neighbourhood care model) should use service performance information to hold health and social providers to account for delivering local targets particularly those relating to adults with learning disabilities.

f) Value the economic impact of investing in social care

The government's Supplementary Green Book Guidance 'Wellbeing Guidance for Appraisal', 2021 uses a "WELLBY' – a one-point change in life satisfaction - as an economic measure for the standard value of improving a person's wellbeing for one life. In 2019 this was estimated to be £13,000. Government should be pro-active in recognising the wider impact of improving social care services on the productivity of the NHS and increasing economic growth as it has begun to do in the impact assessment of the 2024 Employment Rights Bill.

3 Conclusion

Community Integrated Care welcomes the priority being given to social care by the Health and Social Care Select Committee in Parliament. We are keen to contribute to the transformation of the social

care system both as a service in its own right that enables the people we support to live full, healthy and independent lives; and to work as a partner with the NHS to ensure that these two interdependent systems are mutually supportive and work collaboratively to meet the health and wellbeing needs of those we support.

We believe that the time is right for action now to address the many challenges we face in social care within a funded national strategy for change, and with clear and timed milestones to be achieved.

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