Written evidence submitted by More than a Provider Collaborative (ASC0111)

Health and Social Care Select Committee Call for Evidence, Adult Social Care Reform: The Cost of Inaction

About us

More than a Provider Collaborative is a group of six non-profit social care organisations which support people with learning disabilities, autism and complex needs in a person-centred way. We are Brandon Trust, Certitude, Choice Support, Dimensions, Macintyre and United Response. Collectively we support more than 13,000 people and work with 285 local authority partners to deliver care and support worth over £650million each year. From bringing people out of institutions into communities, to delivering employment programmes that bring economic investment to local areas, we have experience of solving some of social care's biggest challenges.

Executive summary

- Adult social care contributes to good health and wellbeing more generally for whole communities of people. It's about prevention as well as hospital discharge.
- Local authorities and the NHS buy 70-80% of all care services. The fee rates they pay now are too low to cover costs.13% of More than Provider contracts are loss making. The risk is that Providers will hand back contracts or close services that are loss making. This would have a detrimental effect on the wellbeing of those who receive support, the staff that deliver them and the NHS and local authorities who will need to provide care and support for them under statutory obligations.
- Care providers have limited control over the price of the care and support they provide because this is set by local government. In London, neighbouring authorities do not pay the same rate for identical care per hour. Commissioning in adult social care is a financially driven procurement model rather than a person-centred one which frequently leads to increased costs in the long term.
- One solution would be to a standardised pricing framework for care and support which could be adjusted based on regional differences such as pay rates and cost of living.
- Integrated health and social care budgets are required to prevent protracted negotiations between ICBs and local authorities about responsibility for the funding of care. This could lead to joint commissioning teams across ICBs and local authorities which would result in efficiencies in staff resources, administration of provider frameworks and contract monitoring.

1. How much is inaction on adult social care reform costing the NHS and local authorities, and what impact does this have on patients and the public?

1.1 The commissioning of support for people with learning disabilities, severe autism and complex needs is focused on a financially driven procurement model. This is a cumbersome annual process driven by the yearly nature of the local government finance settlement. From a Provider perspective, we have no guarantee that the contract fees will cover the cost of care we provide.

1.2 In recent years, commissioners have placed a greater emphasis on the cost element of tenders, risking sacrificing quality of provision and leading to poorer outcomes for individuals. We have seen a shift from 80/20 ratio of quality/cost in tender evaluation to a 60/40 ratio and often even lower.

1.3 This may result in an initial budget saving, but it almost inevitably leads to worse outcomes for individuals and an increased cost to the public purse later. For example, a higher number of safeguarding referrals, a greater number of complaints from individuals and families, more pressure on other services such as mental health provision, police and emergency services and, ultimately, service failure.

1.4 When a Provider fails or gives notice on a contract, this then results in a costly and disruptive procurement process, which is upsetting for the individuals being supported, their families and the staff delivering the support who are likely to be subject to TUPE contract transfer.

1.5 Procurement law and regulation, under the light touch regime introduced as part of the Procurement Act 2023, allows room for commissioners to directly award contracts when there is no realistic alternative Provider, but it isn't fully utilised. All too often, commissioners carry out arduous tender processes when they already know which Provider is best placed to deliver the care and support. Tendering is a costly, resource-intensive and stressful process for commissioners, Providers and the individuals being supported. Most providers would welcome direct awards, even if they were not the recipient, if there was transparency in the decision-making process.

1.6 Local government processes often mean that funding uplifts are paid long after the Provider has incurred increased costs. For example, one More Than A Provider member organisation at the time of writing in December has still has not received confirmation of fee increases for 15% of contracts for 2024/25.

1.8 The increase in Employer National Insurance Contributions and National Living Wage means that at the start of the next financial year in April, Dimensions will face an increase in staff costs of £15 million. National Insurance rises and threshold changes combine to cost Dimensions £5.9m. The increase to the NLW to £12.21 per hour from next April and the organisation's ambition to pay above that wherever possible will increase the wage bill by £10.2 million. These increases to costs give rise to the need for fee uplifts of 8.2%. Currently, average fee uplifts this financial year are 6.3% with some still being challenged. The direct cost to the sector of £800m exceeds the funding provided to local authorities of £680m which will be shared between adult and children's social care. The ability to pay care workers well for the skilled job they do has an impact on recruitment and retention and the continuity and consistency of support for people being supported.

1.9 Until fee increase negotiations have concluded Providers are forced to pay for the increase to staff expenditure out of small cash levels and reserves with no guarantee that this will be reimbursed. These costs are not ones which can be avoided as they are statutory increases in wages and employer NICs.

1.10 As large Providers More than a Provider is assessed by CQC's Market Oversight and cash levels are an area of concern and something which we must maintain to be deemed financially viable.

1.11 This results in Providers assessing the financial viability of our contracts. As More than a Provider we support approximately 13,000 people and of these, 13% are on contracts that are loss making. The risk is that providers will hand back contracts or close services that are loss making. Ultimately affecting the wellbeing of those that receive those services and the staff who deliver them.

1.12 We have limited control over the price of our care and support because it is set by local government. We have examples in London where neighbouring authorities do not pay the same rate for identical care per hour. One solution is a standardised pricing framework for care and support which could be adjusted based on regional differences such as pay rates or cost of living.

1.13 Too much time and resources are taken up by commissioners in ICBs and in local authorities in protracted debates about responsibility for the funding of care. This usually relates to people who may qualify for continuing healthcare funding, in addition to, or instead, of social care funding. The could be prevented if commissioners implemented integrated joint health and social care budgets. This could lead to joint commissioning teams across ICBs and local authorities which would result in significant efficiencies in staff resources, administration of provider frameworks, contract monitoring and simplify the processes for funding care and support.

2. What NHS and local authority service reforms are not happening as a result of adult social care pressures, and what benefits are patients and the public missing out on?

2.1 The widespread closure of non-statutory services means that the services people require such as supported employment aren't available. Recent statistics from the NHS Digital Adult Social Care Activity and Finance report shows that only 4.7% people with a learning disability are in receipt of adult social care and support are in paid employment.

2.2 Employment reforms have consistently overlooked the part that adult social care Providers can successfully play in supporting people into work. Through More Than A Provider's work, we see how generic employment support solutions fail to provide the specialist support that people with a learning disability need to get a job, then thrive in work.

2.3 As employment support services are a non-statutory service local authorities have often had to make the difficult decision to close or scale back supported employment contracts so that they can divert funding to statutory care and support.

2.4 Better joined up working between the Department of Health and Social Care and the Department of Work and Pensions on early action programmes could improve the learning disability employment gap and reduce adult social care expenditure.

2.5 The 'wellbeing' elements of the Care Act is being overlooked and family carers report eight year waiting lists for diagnoses, no support for communication skills for individuals beyond childhood, and a lack of sensory integration and trauma services.

2.6 As the eligibility criteria for care or support has increased and unmet need is rising, learning disabled and autistic people are experiencing greater loneliness, isolation and mental illness.

2.7 Mental health treatment and support is unavailable to people with communication differences and a shortage of services offering support to prepare young people for support in adulthood. This can lead to confusion, the increased use of chemical restraint and a higher number of individuals in crisis.

2.8 The House of Lords Social Care Committee's report Gloriously Ordinary Lives highlighted how the invisibility of adult social care and negative public perception impacts on the long-term reform that is needed in the sector.

2.9 However, delayed reform results in community-based support systems becoming underutilised, weakening the informal networks that could ease the pressure on the NHS and local authorities and enhance social cohesion.

3. What is the cost of inaction to individuals and how might people's lives change with action on adult social care reform?

3.1 The lack of a workforce plan for social care means that there is increasing unmet need for working aged disabled people.

3.2 Although Education, Health and Care Plans (EHCPs) were supposed to reduce the cliff-edge into adult social care, the reality is, it still exists. There should be better transitions planning for those born with a disability and reform should consider how an individual may need to be supported from birth to death.

3.3 Insufficient social care as a result of unmet need restricts individuals' ability to engage in meaningful social, cultural, and community activities, often leading to isolation and declining mental health.

3.4 It also has an impact on an people's ability to be economically active. This can lead to increased mental health challenges, including anxiety and depression. Ultimately this affects people's independence and wellbeing by reducing their ability to learn new skills or engage in fulfilling work.

3.5 Inaction also affects families across generations. Younger family members often face disruptions in education, career, and mental health due to caregiving responsibilities or the emotional impact of seeing a loved one unsupported.

Case study:

Sarah (not her real name), a 28-year-old with learning disabilities and autism, has been supported by one of the More than a Provider organisations for three years. Sarah requires consistent intensive and individualised support to manage her anxiety, self-harm and communication challenges. Despite this, Sarah's care package remains categorised under the "standard rate," as her needs are not currently recognised as "complex" by the commissioning framework.

Challenges:

1. **Underestimated Support Needs:**
    - Sarah's support involves managing sensory sensitivities, providing constant 1:1 staffing to prevent self-harm, and implementing a tailored positive behaviour support (PBS) plan. While these interventions prevent crisis situations and hospitalisations, they are resource-intensive and align more closely with complex care criteria.
    - The standard rate does not reflect the additional staff training, specialised resources, and consistent monitoring required to support Sarah's wellbeing effectively.
2. **Financial Implications:**
    - The standard rate reimbursement does not cover the actual costs incurred to maintain Sarah's wellbeing and prevent escalation of her needs. As a result, we must divert resources from other areas, which places financial strain on the organisation.
3. **Missed Opportunities for Preventative Care:**
    - Without recognition of Sarah's evolving needs, the Provider is limited in its ability to access funding for additional therapeutic interventions or assistive technologies that could further enhance her independence and quality of life.

Efforts to Seek Reassessment:
Using the commissioning framework's own criteria, we identified Sarah as one of 12 individuals warranting reassessment for complex care rates. However, despite presenting detailed evidence of her needs, the request was declined, with a suggestion to revisit the case during the next scheduled review in 12 months.

Impact:
This decision has created a delay in securing the necessary funding to provide the level of care Sarah requires, potentially risking her wellbeing and increasing long-term costs if her needs escalate.

Proposed Solution:
We requested a more flexible and timely reassessment process that acknowledges evolving care needs and considers input from providers who have direct, day-to-day experience supporting individuals like Sarah. By aligning funding levels with actual support needs, we can:

- Deliver care that better promotes wellbeing and independence.
- Reduce the likelihood of crises and emergency interventions, ultimately leading to cost savings for the commissioning body.

4. Where in the system is the cost of inaction on adult social care reform being borne the most?

4.1 Skills for Care research shows there are currently 131,000 vacancies in the adult social care workforce. This means that many of the most vulnerable people who rely on care and support are not consistently supported by someone they know because of high turnover rates caused by low pay and terms and conditions. For Providers this means higher costs for agency staff. There is an urgent need for a workforce plan, like the one developed by Skills for Care.

4.2 Family caregivers often experience strained relationships, as they juggle their roles without adequate support, which can lead to family conflict, stress, and compromised health and wellbeing.

4.3 It is costing the NHS to keep people in hospital – thousands locked up in inappropriate and traumatising assessment and treatment units at much higher cost than having appropriate housing and support in their community.

4.4 Despite policies by successive governments over decades, there are still more than 2000 autistic people and people with a learning disability detained in Assessment and Treatment Units. They are often detained in ATUs against their will, long distances from home and families are often unaware of what is happening to their loved ones. Of these, approximately 67% are autistic. This is a 116% increase in the number of autistic people without a learning disability detained since March 2015.

4.5 We welcome changes in the Mental Health Bill to limit detention for people with a learning disability and autistic people with no co-occurring mental health but we need an overhaul of the system to ensure support in the community is available.

4.6 The absence of capital grants and limited suitable, accessible and affordable housing means that people with learning disabilities and complex autism are often placed in unsuitable housing.

4.7 There is a lack of positive risk-taking which results in people regularly being kept waiting in hospital while housing departments tackle lengthy bureaucracy and submit a business case for funding. Local authorities are not incentivised to support discharge as the money doesn't follow the person.

4.8 We often rely on the private sector to provide this kind of housing, but we then face barriers with the local authority housing benefit departments who deem the rents to be too high. Adaptations can't be funded through service charges and local authorities are discouraged from souring housing from non-registered housing providers.

Case study:

One of the Providers in the Collaborative carried out an assessment for a Forensic referral of Peter (not his real name) for a hospital discharge. The Provider assessed it could support Peter, but it would require a bespoke rate. The contract was awarded to another Provider which offered a lower rate, but they delayed his release from hospital, and they ended up not being able to support him. Peter stayed in hospital which affected his mental health. If Peter had been able to be supported in the community this is likely to have reduced the cost of his support in comparison with hospital in the long term.

5. What contribution does adult social care make to the economy and HM Treasury and how might this change with action on reform?

5.1 Effective social care enhances productivity, as fewer working-age family members need to leave or reduce their working hours to provide care.

5.2 Investing in social care supports more stable communities by reducing displacement and the breakdown of family units, allowing individuals to remain active contributors within their communities.

5.3 Although wellbeing is the primary tenet of the Care Act 2014, little has been done to measure or evaluate the economic value that adult social care brings through the delivery of this piece of legislation. Wellbeing-adjusted Life Year or WELLBY, is recognised as a way to consistently measure and value improvements in wellbeing. The Treasury, in its own guidance defines a WELLBY as: a change in life satisfaction of one point on a scale of 0-10, per person per year. It recommends a value of £13,000 per WELLBY.

5.4 If commissioning practices were reformed so that adult social care was commissioned based on outcomes, such as wellbeing, as opposed to commissioning by the hour, the sector could more effectively measure the economic value of social care.

5.5 By using wellbeing measures in adult social care, in addition to an assessment of the quality of Providers, it could lead to more effective evaluation of outcomes for individuals. This would give individuals in receipt of care and support greater control in a system which is largely determined by provider's ability to tender successfully.

6. To what extent are the costs of inaction on adult social care reform considered by the Government when evaluating policies, including within the Budget and Spending Reviews? How should these costs be assessed and evaluated?

6.1 The cumulative mental health and relational impacts on families and care givers due to inaction in social care policy should be factored into government planning.

6.2 By incorporating family and community-based perspectives in policy development, policymakers would be able to view reform through the lens of family wellbeing and community resilience. This would result in more comprehensive, impactful solutions.

6.3 Policy reforms should place dignity, autonomy, and individual wellbeing at the forefront, considering the unique challenges families face. Impact assessment should look at the estimated value added by improved wellbeing.

6.4 Engaging communities in the reform process could yield innovative, sustainable solutions that reflect the real-world needs of families and social care recipients.

6.5 Investing in social care not only addresses a national crisis but also supports the emotional and economic health of society.

December 2024