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A better old age? Improving health and care outcomes for the over-65s in the UK

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Introduction

Britain's health and care system is in a precarious state. The pressures of an ageing population, common to many industrialised countries, are being compounded by post-pandemic waiting lists for National Health Service (NHS) treatment which number around 7.7 million people.[1] Public satisfaction with the NHS has fallen to historic lows of 24%, a drop of 29 percentage points since 2020.[2] Part of the problem is insufficient social care capacity, which is overburdening hospitals. At times, up to a third of hospital beds in some regions have been occupied by older people who are medically fit for discharge but who cannot live independently, and cannot get access to social care.[3]

Satisfaction with social care is even lower with only 13% of the British public reporting satisfaction with the system. Already, the system is failing to meet the demands placed upon it. Currently, 16% of people aged between 65 and 74 struggle with one or more of the activities of daily living (ADL), according to the English Longitudinal Study of Ageing (ELSA).[4] Of those aged 85+, 44% struggle with one or more ADLs. AgeUK estimates that 1.6 million people over 65 have unmet needs for care and support.[5]

To make matters worse, demand for social care from the over-65s in England is increasing as the population ages and grows. The annual number of requests for social

[1] Royal College of Surgeons, 'NHS Waiting List in England Hits Record 7.7 Million', Royal College of Surgeons, 14 September 2023, https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/nhs-waiting-list-hits-record-high/.
[2] National Centre for Social Research, 'Public Attitudes to the NHS and Social Care', National Centre for Social Research, 27 March 2024, https://natcen.ac.uk/publications/public-attitudes-nhs-and-social-care.
[3] Nicola Davis and Carmen Aguilar García, 'Up to One in Three English Hospital Beds Occupied by Patients Fit for Discharge', *The Guardian*, 13 November 2022, sec. Society, https://www.theguardian.com/society/2022/nov/13/hospital-beds-england-occupied-patients-fit-discharge.
[4] English Longitudinal Study of Ageing (ELSA)), 'Accessing ELSA Data', ELSA, 2019, https://www.elsa-project.ac.uk/accessing-elsa-data.
[5] Chloe Reeves, Aisha Islam, and Tom Gentry, 'The State of Health and Care of Older People in England 2023' (AgeUK, July 2023), 35, https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/age_uk_briefing_state_of_health_and_care_of_older_people_july2023.pdf.

care to local authorities by over-65s rose from 1.32 million to 1.37 million requests between 2017/18 and 2021/22.[6] Furthermore, projections by the Health Foundation suggest that 1 in 5 people in England could be living with major illness in less than two decades' time as the prevalence of chronic diseases increase.[7]

Compounding the problems has been a lack of meaningful reform by both main political parties. In 2010, a Labour proposal to fund universal social care through a new inheritance tax was dropped after being labelled a 'death tax'.[8] In 2017, a Conservative manifesto pledge to increase individuals' contributions towards social care was dropped after being criticised as a 'dementia tax'.[9] The 2021 Conservative plan for a Health and Social Care levy was dropped in 2022.[10] All attempts at setting the financing of elderly care on stronger ground have failed in part because of the political difficulty of raising taxes to fund a system which few voters understand, for a sector which has had little voice.

However, a new opportunity to rethink how health and social care are organised in the UK might now be presenting itself. The COVID-19 pandemic response shone a spotlight on the vulnerable and elderly in residential care homes; it has increased public awareness of what social care is and how it works, also driving up public desire for change. The 2022 British Attitudes Survey found that 57% of respondents reported being dissatisfied with the pay, working conditions and training for social care workers.[11] More people are also realising that the system is overwhelmed, and that

[6] Reeves, Islam, and Gentry, 27.
[7] Toby Watt et al., 'Health in 2040: Projected Patterns of Illness in England' (The Health Foundation, July 2023), https://reader.health.org.uk/projected-patterns-of-illness-in-england.
[8] Nicholas Watt and chief political correspondent, 'Spectre of "death Tax" Haunts Andy Burnham's Care Revolution', *The Guardian*, 30 March 2010, sec. Politics, https://www.theguardian.com/politics/2010/mar/30/death-tax-haunts-andy-burnham-care-revolution.
[9] Charlie Cooper, 'Theresa May Backtracks on Key Manifesto Pledge on Elderly Care', POLITICO, 22 May 2017, https://www.politico.eu/article/theresa-may-backtracks-on-key-manifesto-pledge-on-elderly-care/.
[10] Antony Seely and David Foster, 'Health and Social Care Levy' (House of Commons Library, 22 November 2022), https://commonslibrary.parliament.uk/research-briefings/cdp-2021-0139/.
[11] Nuffield Trust, 'British Social Attitudes Survey: Public Satisfaction with Social Care Hits New Low', Nuffield Trust, 25 March 2024, https://www.nuffieldtrust.org.uk/news-item/british-social-attitudes-survey-public-satisfaction-with-social-care-hits-new-low.

funding is complex, patchy and unfair. This opens the possibility of devising a new offer to the British public to fund a more secure, fulfilling old age. There is also now a greater prospect of cross-party agreement, with all three main political parties accepting the need for reform.

A sustainable, long-term funding solution for social care is urgently needed. Yet that alone will not fix systems of health and care which are disjointed, hard to navigate, and which do not sufficiently prioritise outcomes for older people. The animating question of this paper is **how can policy most effectively improve outcomes for the over-65s?** Our analysis focuses on the policy levers available to ministers in six areas: the NHS/social care interface; technology, workforce, commissioning and regulation; user empowerment; and funding. In each area we attempt to identify high level policy options with the greatest potential impact, and highlight those which could be delivered within the first year of a new government. The report is structured in six chapters:

In **Chapter 1: the NHS-social care interface**, we analyse how the over-65s move between parts of the NHS and social care, with a focus on the contentious issue of hospital discharge. We identify five "critical episodes" when older people can either maintain or lose independence, and become permanently reliant on long-term social care. Intervention at these critical episodes can be cost effective; and we make recommendations for improving those interventions.

Chapter 2: Using data and technology considers the role that technology and data-sharing can play in helping to maintain independence, and improve the interface between the NHS and social care. We find that social care lags behind the NHS in terms of digitisation, and that progress in joining up systems is too slow, but that technology offers significant potential to free up staff workloads and empower older people.

Chapter 3: The care workforce analyses the state of the social care workforce including turnover, pay, terms and conditions. We find that the domiciliary care market, in particular, has become even more unstable since the pandemic. We analyse delegated healthcare tasks which could be undertaken by care workers and propose ways to stabilise and professionalise the workforce.

Chapter 4: Driving up quality: commissioning and regulation considers how to improve the quality of social care through commissioning and regulation, in the context of the newly statutory Integrated Care Systems (ICSs). There is much to learn from pioneering local authorities and other countries about how to create person-centred services which focus on giving individuals a fulfilling life, not simply managing decline.

In **Chapter 5: Empowering the citizen**, we look at the lack of choice in this quasi-market in which consumers are weak. We consider what is preventing families and users from exercising autonomy and consider the ways in which user empowerment can be improved.

Chapter 6: Social care funding analyses why adequate funding for social care has proved so politically difficult for successive governments, and looks around the world for potential models. We set out criteria for the development of a comprehensive, transparent and sustainable funding package. We suggest that such a package must be crafted with reference to existing benefits and pensions.

This report builds on interviews with expert stakeholders in the NHS and social care undertaken between December 2023 and April 2024. It draws on Baroness Cavendish's Independent Review of Social Care Reform, written in 2020 and published by the Department of Health and Social Care (DHSC) in 2022; and uses evaluation caseload and expenditure statistics. We propose the following recommendations across our six thematic areas:

Recommendations

On the Interface with the NHS

1. Develop a relentless focus on promoting the independence of over-65s in both the NHS and social care, avoiding unnecessary hospital admission and turbo-charging rehabilitation

On using data and technology to improve outcomes for older people

2. Accelerate the digitisation of health and care records, promote data-sharing and technology to reduce frontline workloads and improve the integration of health and care

On the social care workforce

3. Create a new deal on care worker pay and progression linked to a nationally agreed list of delegated healthcare tasks

On commissioning and regulation

4. Stabilise care markets, moving away from procuring by the minute towards commissioning for outcomes, with fair fees paid to providers as part of a secure funding settlement

On empowering the citizen

5. Help citizens to choose and co-design their own care by expanding direct payments and improving information

On funding long-term care

6. Create a comprehensive, sustainable and transparent funding plan which pools risk nationally, with national eligibility criteria and a wide base of contributions: underpinned by a narrative which explains the public benefits of investment in social care

Methodology

Our analysis draws on qualitative and quantitative methodologies. Qualitatively, we relied on an extensive literature review and interviews with expert stakeholders between 2023 and 2024 to develop an understanding of current issues for the over-65s within the UK health and social care systems. We also carried out a review of international best practices in countries facing similar demographic challenges.

Special thanks are due to Natasha Curry of the Nuffield Trust, Penny Dash of NW London ICS, Tom Riordan of Leeds Council, Professor Tim Ferris, Jane Townson of UKHCA, and Daniel Sperrin of Newton. The main datasets we rely upon include:

Thematic area	**Main datasets used**
Workforce	1. Skills 4 Care ASC workforce dataset https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/Topics/Monthly-tracking/Monthly-tracking.aspx 2. ONS Labour Force Survey (UK) https://www.ons.gov.uk/surveys/informationforhouseholdsandindividuals/householdandindividualsurveys/labourforcesurvey 3. ONS JOBS02 Workforce Jobs dataset https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/workforcejobsbyindustryjobs02
Public expenditure	1. DWP Benefits August 2023 statistical release, available at: https://www.gov.uk/government/statistics/dwp-benefits-statistics-august-2023/dwp-benefits-statistics-august-2023 2. NHS England CHC & FNC statistical release, Q4-2022/2023 & correspondence with CHC Data https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/05/CHC-and-FNC-Statistical-Release-Q4-2022-23_ME27h.pdf

NHS & Social Care Performance	1. Adult Social Care Outcomes Framework, NHS England Digital https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof 2. Adult Social Care Activity and Finance Report, NHS England Digital https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report 3. Acute discharge situation report, NHS England Digital https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays-acute-data/
Population Characteristics	1. English Longitudinal Study of Ageing https://www.elsa-project.ac.uk/accessing-elsa-data
Public Opinion	1. The National Centre for Social Research (NatCen)'s annual British Social Attitudes (BSA) survey, available at https://natcen.ac.uk/publications/public-attitudes-nhs-and-social-care 2. Engage Britain's 2020-2022 polling on health and social views, available at: https://engagebritain.org/health-care-where-are-we-up-to/

Scope of analysis

This report focuses on the over-65s within the NHS and Adult Social Care (ASC), not disabled adults of working age who constitute an important part of ASC. It does not address preventative health. Where it has not been possible to break out data by age, or to separate the two parts of ASC, we make that clear. Our analysis looks at the whole of the UK where possible, but some data applies only to England and Wales, reflecting the different regimes in Scotland and Northern Ireland. Again, we attempt to make clear where that is the case.

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Glossary

ADL	Activities of Daily Living, activities relating to personal care and mobility about the home that are fundamental to daily living.
ASCAF	Adult Social Care Activity and Finance Report, published annually by NHS England, aggregates data from 152 local authorities to provide insight into adult social care activity and expenditure.
ASCOF	Adult Social Care Outcomes Framework, published annually by NHS England, measures how well care and support services achieve key outcomes.
ASC	Adult Social Care, the provision of non-medical care services to disabled working adults and the over-65s.
BCF	Better Care Fund, a funding programme aimed at integrating health and social care authorised under Section 75, NHS Act 2006.
CCG	Clinical Commissioning Groups, NHS organisations set up to plan delivery of services. Since 2022, CCGs have been replaced by ICSs (see below), however older literature still makes references to CCGs.
CMA	Competition and Markets Authority, the UK competition regulator.
CQC	Care Quality Commission, an executive non-departmental agency of the Department of Health and Social Care which inspects and regulates health and social care providers.
DHSC	Department of Health and Social Care, the department of state responsible for the provision of health and social care.
DiSC	Digitalisation of Social Care.
DWP	Department of Work and Pensions, the department of state responsible for welfare, pensions and child maintenance.
EHR/EMR/EPR	Electronic Health Record/Electronic Medical Record/Electronic Patient Record; used interchangeably to refer to digital patient medical records that is maintained by the provider, and includes medical history, diagnoses, medications, treatment plans, vaccination history, test results etc.
FDP	Federated Data Platform, interoperability platform that allows NHS trusts and Integrated Care Systems to share data and access operational tools and products.

ICB	Integrated Care Board, a statutory NHS body within an ICS (see below) responsible for meeting health needs of local population, commissioning services (including those previously planned by clinical commissioning groups (CCGs)), and managing NHS budget and resources.
ICS	Integrated Care System, a statutory partnership between NHS organisations, local authorities, and care organisations, to collectively plan and deliver health and care services across a geographical area.
LGA	Local Government Association, the national membership body for local authorities in England and Wales.
LTC	Long-term care, the provision of services to meet medical and non-medical needs of people with chronic illness or disability.
MDT	Multi-disciplinary Team, a team of professionals from different disciplines to provide comprehensive and coordinated care that addresses the varied needs of a patient. The composition of an MDT can vary based on the setting (e.g., hospital, community) and the specific needs of the population it serves (e.g., cancer patients, elderly care, mental health).
NHS	National Health Service, the publicly funded healthcare system in the UK.
OPTICA	Optimised Patient Tracking and Intelligent Choices Application, a secure cloud application used by the NHS to track patients through hospital journeys.
OTs	Occupational therapists.
RCN	Royal College of Nursing, the registered trade union and professional body for nurses in the UK.
SCIE	Social Care Institute for Excellence, an independent charity and improvement agency in social care.

1. Keeping people independent for longer: the interface with the NHS

Recommendation:

Develop a relentless focus on promoting the independence of over-65s in both the NHS and social care, avoiding unnecessary hospital admission and turbo-charging rehabilitation

The postwar NHS was designed as a top-down system focused on episodic care, a "patch and repair" service. But today, more than half of its budget is spent on treating chronic long-term conditions, with patients who make multiple repeated visits to hospitals, GPs, and community care settings.[12] The 1948 dividing lines between primary and secondary care remain, prevention is poorly funded, and there is a gulf between the NHS and social care services, which has recently erupted in a blame game over who bears responsibility for delayed transfers from hospitals.

While the NHS has hired more and more staff over the past decade**,** it has not trained or hired enough of the staff most relevant to elderly care: GPs, geriatricians, district nurses, occupational therapists and physiotherapists.[13,14] Shortages of all of these are a barrier to improving the offer for older people. Ideally GP practices would develop more of a geriatric focus, holding the hand of the over-65s through the health and care system and making innovative partnerships with third party providers. But falling numbers (as reported in the NHS England General Practice Workforce dataset), heavy workloads, and emotional strain make this an unrealistic ambition, at least in the short-term.[15]

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[12] 'Care and Support for Long Term Conditions', Nuffield Trust, accessed 13 May 2024, https://www.nuffieldtrust.org.uk/resource/care-and-support-for-long-term-conditions.
[13] 'NHS Workforce Statistics', NHS England Digital, accessed 13 May 2024, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics.
[14] 'New BGS Report Exposes Continuing Shortage of Geriatricians', British Geriatrics Society, accessed 13 May 2024, https://www.bgs.org.uk/policy-and-media/new-bgs-report-exposes-continuing-shortage-of-geriatricians.
[15] NHS England, 'General Practice Workforce' (England: NHS England, 27 April 2023), https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-march-2023#; Commonwealth Fund, 'UK GPs Suffering Unsustainable Workplace

A single fall or acute illness can be the initial event that heralds an intensive period of health and social care use, triggering a loss of independence which is often never fully regained for older adults. The right kind of prevention, treatment and rehabilitation could save many more people from becoming dependent. We identify five "critical episodes" when the difference could be made between someone over-65 remaining independent, and becoming permanently reliant on social care.

Five critical episodes which threaten independence

1. Falls, especially falls which lead to fractures. Around 10% of all ambulances are called out for over-65s who have fallen over, costing the NHS around £1 billion a year.[16] Around half of those who fracture a hip in a fall subsequently become dependent on others for daily living.

2. Unnecessary hospital admissions. Older people rapidly decondition in hospital. Around 30–60% of over-65s lose functional status during a hospital stay, and 50% can become incontinent within 48 hours of admission.[17]

3. De-conditioning while in hospital. Patients who are discharged having deconditioned are three times more likely to be readmitted within 30 days.[18]

Pressures', accessed 7 May 2024, https://www.health.org.uk/news-and-comment/news/uk-gps-suffering-unsustainable-workplace-pressures.

[16] Amy Charters, 'Falls Prevention Exercise - Following the Evidence' (AgeUK, June 2013), https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/rb_2013_falls_prevention_guide.pdf; J. Leal et al., 'Impact of Hip Fracture on Hospital Care Costs: A Population-Based Study', *Osteoporosis International: A Journal Established as Result of Cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA* 27, no. 2 (February 2016): 549–58, https://doi.org/10.1007/s00198-015-3277-9.

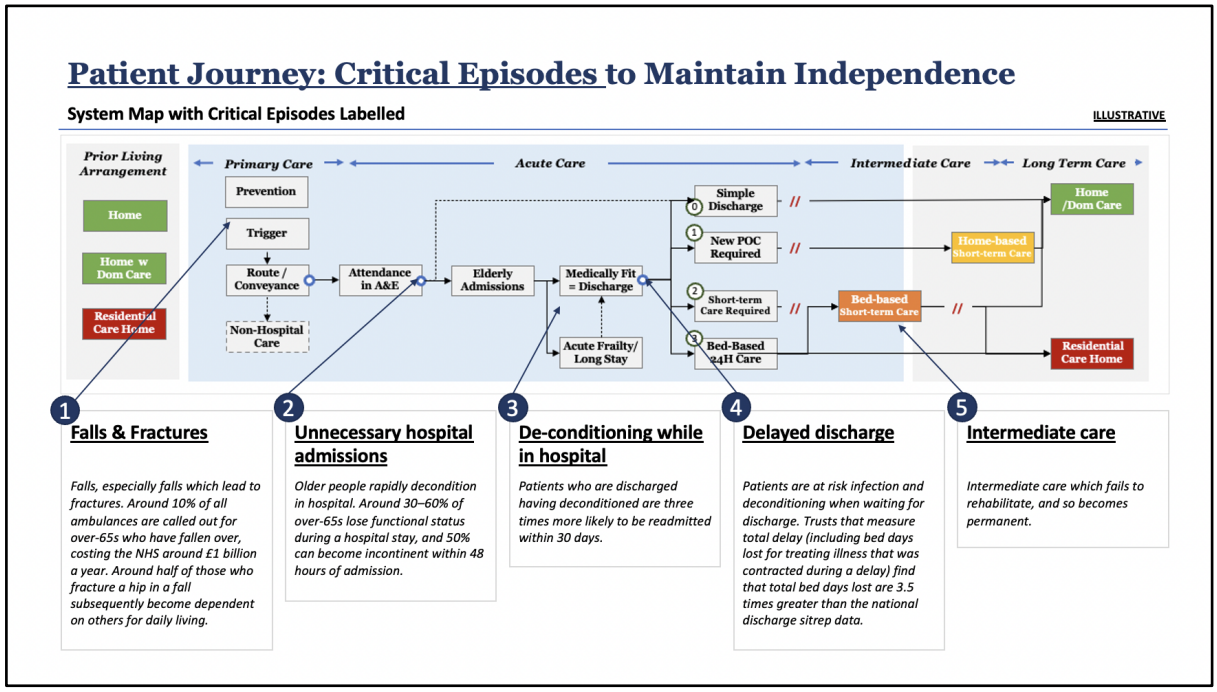
[17] Daniel Liebzeit, Lisa Bratzke, and Barbara King, 'Strategies Older Adults Use in Their Work to Get Back to Normal Following Hospitalization', *Geriatric Nursing (New York, N.Y.)* 41, no. 2 (2020): 132–38, https://doi.org/10.1016/j.gerinurse.2019.08.003; Amit Arora, 'Recondition the Nation', *Recondition the Nation* (blog), 10 March 2023, https://www.england.nhs.uk/blog/recondition-the-nation/.

[18] Toby O. Smith et al., 'Interventions for Reducing Hospital-Associated Deconditioning: A Systematic Review and Meta-Analysis', *Archives of Gerontology and Geriatrics* 90 (2020): 104176, https://doi.org/10.1016/j.archger.2020.104176.

4. Delayed discharge. Patients are at risk of infection and deconditioning when waiting for discharge. Trusts that measure total delay (including bed days lost for treating illness that was contracted during a delay) find that total bed days lost are 3.5 times greater than the national discharge sitrep data.

5. Intermediate care which fails to rehabilitate, and so becomes permanent.

Figure 1: Patient Journey: Critical Episodes



Critical episode 1: falls and fractures

Falling is frightening; it undermines confidence and can sometimes lead to serious damage. In the UK, around 1 in 3 adults over 65 and half of those over 80 will fall at least once a year.[19] Around half of those who fracture a hip in a fall subsequently become dependent on others for daily living; a study in Utah, USA, found that women are

[19] 'Falls - NHS', accessed 19 May 2024, https://www.nhs.uk/conditions/falls/.

particularly at risk.[20] Fear of falling can lead to diminished physical activity in the elderly, which can reduce quality of life.[21]

The most common modifiable risk factors for falls are gait deficits and poor muscle strength and balance. Strength and balance training has been shown to halve the risk of falls.[22] They also strengthen muscle and bone density, making a fracture less likely even if someone does fall over.[23] But while there are many falls prevention programmes around the country, access is patchy. There is also relatively little promotion of the Chief Medical Officer's guidelines for older adults, which advise that people do two sessions of strength and balance exercise a week: despite there being exercise videos available through the NHS app.[24]

In Japan, the incidence of falls among the over-65s is around 20% a year, compared to 30% in America and Europe.[25] This significant gap is attributed partly to a more holistic use of interventions including Tai chi, Vitamin D supplementation, de-prescribing, especially of psychotropic medication, and home adaptations.[26] The latest Cochrane

[20] Suzanne M. Dyer et al., 'A Critical Review of the Long-Term Disability Outcomes Following Hip Fracture', *BMC Geriatrics* 16, no. 1 (2 September 2016): 158, https://doi.org/10.1186/s12877-016-0332-0; Women are more likely to fall than men due to a number of factors, including hormone changes during menopause, reduced muscle mass, and increased gait variability during multitasking. A. J. Campbell, G. F. Spears, and M. J. Borrie, 'Examination by Logistic Regression Modelling of the Variables Which Increase the Relative Risk of Elderly Women Falling Compared to Elderly Men', *Journal of Clinical Epidemiology* 43, no. 12 (1990): 1415–20, https://doi.org/10.1016/0895-4356(90)90110-b.
[21] D.P Gill et al., 'Effect of Falling on Physical Activity in Community-Dwelling Older Adult Males', *American Journal of Epidemiology* 163, no. suppl_11 (1 June 2006): S175, https://doi.org/10.1093/aje/163.suppl_11.S175-d.
[22] Royal College of Physicians, 'Exercise for Life: Physical Activity in Health and Disease' (Royal College of Physicians, March 2015), https://www.rcplondon.ac.uk/file/1287/download.
[23] Lesley D. Gillespie et al., 'Interventions for Preventing Falls in Older People Living in the Community', *The Cochrane Database of Systematic Reviews* 2012, no. 9 (12 September 2012): CD007146, https://doi.org/10.1002/14651858.CD007146.pub3.
[24] Chief Medical Officer, 'Guidelines for Older Adults' (DHSC), accessed 7 May 2024, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831435/Withdrawn_Physical_Activity_Adults_Infographic.PDF.
[25] Masahiro Sakita et al., 'Falls and Fall Prevention in Elderly People: Summary of Recent Reviews', *Japanese Journal of Health Promotion and Physical Therapy* 4, no. 4 (2015): 161–69.
[26] Tsung-Jen Hsieh et al., 'Individualized Home-Based Exercise and Nutrition Interventions Improve Frailty in Older Adults: A Randomized Controlled Trial', *The International Journal of Behavioral Nutrition and Physical Activity* 16, no. 1 (2 December 2019): 119, https://doi.org/10.1186/s12966-019-0855-9.

Review of 10 countries finds that the rate of falls can be reduced by a quarter, by decluttering and reducing trip hazards in the homes of those who are at high risk.[27]

Predicting who is most at risk is therefore important. An umbrella review, published by D. Beck Jepsen et al., found that no single gait, balance, or functional mobility assessment in isolation could be used to predict fall risk in older adults with high certainty.[28] But since then a number of companies have developed algorithms which claim to improve prediction. Cera Care, a digital-first healthcare-at-home company, claims its algorithm can predict 83% of falls a week before they happen; Cera was able to reduce falls by 20% in the first two weeks after rollout amongst people they care for.[29]

Coding for frailty might help. In an analysis in Camden, people with severe frailty were twice as likely to have a fall-related hospital admission (31%) compared to those who were mostly healthy (16%).[30] But although NHS England introduced the Electronic Frailty Index (eFI) in 2016 to help GPs identify frailty in older adults and direct them to Falls Prevention Programmes and Community Independence Services interviewees have suggested that it is not widely used. One GP described frailty assessments as "hand-wavey and inaccurate".[31] Eight years after its introduction, it would be wise to evaluate how the eFI is being used.

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[27] Lindy Clemson et al., 'Environmental Interventions for Preventing Falls in Older People Living in the Community', *Cochrane Database of Systematic Reviews*, no. 3 (10 March 2023), https://doi.org/10.1002/14651858.CD013258.pub2.

[28] D. Beck Jepsen et al., 'Predicting Falls in Older Adults: An Umbrella Review of Instruments Assessing Gait, Balance, and Functional Mobility', *BMC Geriatrics* 22 (25 July 2022): 615, https://doi.org/10.1186/s12877-022-03271-5.

[29] 'AI-Enabled Home Healthcare Provider Cera Care to Save the UK Government & Hospitals £100M This Winter by Committing to 5 Million Care Visits', 24 November 2023, https://www.businesswire.com/news/home/20231124678204/en/AI-enabled-Home-Healthcare-Provider-Cera-Care-to-Save-the-UK-Government-Hospitals-%C2%A3100M-This-Winter-by-Committing-to-5-Million-Care-Visits.

[30] Camden Council, 'Frailty Analysis: Managing The Care Of Older People With Frailty | Open Data Portal', London Borough of Camden, accessed 7 May 2024, https://opendata.camden.gov.uk/Health/Frailty-Analysis-Managing-The-Care-Of-Older-People/xuxf-yskm.

[31] NHS England, 'NHS England » Identifying Frailty', accessed 7 May 2024, https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-risk-identification/.

In the UK, care workers and other staff who are not medically trained are not permitted to lift a person who has fallen, under the Health and Safety Act (Manual Handling Operations Regulations 1992). They are generally told to make the person comfortable and to contact the Emergency Services.

The Japanese experience suggests that home adaptations, and strength and balance exercises, should be rolled out more comprehensively.

Critical episode 2: unnecessary hospital attendances of 65+

In 2022/23, 4.99 million A&E attendances were people aged 65 or over (out of a total 25.35 million visits).[32] There were 2.59 million emergency admissions, of which approximately 1.6 million were consultant-led A&E admissions, and the remaining were through urgent care centres, GP referral, or planned admissions that required emergency care.[33] Common reasons for admission included falls & injuries, respiratory illnesses, and infections (often UTIs).

Up to a third of admissions of over-65s are inappropriate or avoidable, according to research co-produced by the Country Councils Network (CCN) and Newton.[34] They estimate that tackling even a third of these avoidable admissions would have a transformative impact: resulting in 175,000 fewer admissions and £0.6 billion in savings for the NHS.[35]

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[32] 'Hospital Accident & Emergency Activity, 2022-23', NHS Digital, accessed 7 March 2024, https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2022-23.

[33] Approximately 1.6M Type 1 and Type 2 admissions; the remaining 1M were Type 3 or 4 admissions. 'Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency Data, April 2022 - March 2023 (M13)', NHS Digital, accessed 7 March 2024, https://digital.nhs.uk/data-and-information/publications/statistical/provisional-monthly-hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data/april-2022---march-2023-m13.

[34] Analysis by Newton and County Councils Network, "Finding the way home", November 2023. A multidisciplinary group looked at a sample of 539 patients across five health and social care systems.

[35] 'Newton and CCN - Finding a Way Home for Website', County Councils Network, accessed 6 March 2024, https://www.countycouncilsnetwork.org.uk/new-report-sets-out-how-hospital-admissions-can-be-avoided-and-how-patient-flow-can-be-improved-ahead-of-busy-winter-period/newton-and-ccn-finding-a-way-home-for-website/.

The most common route for inappropriate hospital attendances is by ambulance. This is due to a combination of:

- care workers not feeling confident to deal with the situation themselves;
- care homes nervous about liability;
- GPs unavailable;
- 111 is risk-averse: at least 1 in 20 callers is sent unnecessarily to A&E (BMJ 2019)[36]
- paramedics taking people to hospital, even if there is a DNR in place;
- NHS staff lacking knowledge of, and confidence in, alternative community services.

Older people who arrive in A&E are more likely to be admitted, and to stay longer once there. Anna, a junior elderly medicine doctor, told us that *"even if older people have a preference for "no hospital admission" it doesn't matter in A&E; doctors are too concerned about negligence"*.

Research recently published in the Health Service Journal (HSJ) demonstrates that those Integrated Care Boards (ICBs) that invest more in their community care see up to 15% fewer emergency admissions.[37] Yet most national guidance, and support programmes, are focussed on optimising discharge rather than avoiding admissions. National data collection (e.g. discharge delay sitreps), focus on people with no criteria to reside in the hospital, with little consideration of those who could have avoided an admission altogether.

Evidence suggests that multidisciplinary teams are having some success in identifying patients suitable for alternative community services. The Leicestershire, Leicester City,

[36] Mark Egan et al., 'Identifying the Predictors of Avoidable Emergency Department Attendance after Contact with the NHS 111 Phone Service: Analysis of 16.6 Million Calls to 111 in England in 2015–2017', *BMJ Open* 10, no. 3 (1 March 2020): e032043, https://doi.org/10.1136/bmjopen-2019-032043.
[37] Health Service Journal. (25 September 2023) Revealed: the ICSs where delayed discharge rates have doubled in a year. https://www.hsj.co.uk/quality-and-performance/revealedtheicss-where-delayed-discharge-rates-have-doubled-inayear/7035583.article

and Rutland ICB has created an "unscheduled care hub" where a team of paramedics, GPs, geriatricians, advanced practitioners, social workers, community nurses, therapists, and mental health workers work together to triage ambulance calls in real time. Early reports suggest this programme has saved the ambulance service time and resources, and enabled more people to be treated in their own home. At the end of 2022, between 40-50 patients per day were diverted from A&E to community services via the unscheduled care hub; 93% of patients are extremely likely or likely to recommend to friends and family.[38,39]

Interviewees generated a range of other solutions. One would be to put a GP at the front door of every A&E: where this has been tried, up to a third of all patients have been treated and sent home, without admission to hospital. Another would be to have a consultant geriatrician in every A&E, since they are more aware of the risks of deconditioning. Alternatively, to create a Frailty MDT (consultant-led, with a specialist nurse, OT, and/or physio) or Acute Frailty Assessment area within A&E. Studies show that early assessment by a frailty team can reduce readmissions: in one case by emergency admissions decreased from 69.6 to 61.2% in people aged 85+, and readmission rates in this group fell from 26.0% at 90 days to 19.9%.[40]

For frail patients with intense medical needs, virtual wards ("hospital-at-home") can be an attractive alternative. The UK is a leader in virtual wards, with approximately 12,000 virtual ward beds at 73% occupancy.[41] The main challenge is staffing virtual wards, especially when specialist teams are needed, such as respiratory MDTs, which recruit

[38] 'Paper F - ICB Paper F - Winter Plan 2023-24.Pdf', accessed 13 May 2024, http://www.library.leicestershospitals.nhs.uk/pubscheme/Documents/How%20we%20make%20decisions/Board%20Papers/(2023)%20-%20Thursday%2012%20October%202023/Paper%20F%20-%20ICB%20Paper%20F%20-%20Winter%20Plan%202023-24.pdf.

[39] Anna Olek, 'Local NHS Steps up Winter Plans and Calls on Public to "Get in the Know"', *LLR ICB* (blog), 8 December 2022, https://leicesterleicestershireandrutland.icb.nhs.uk/local-nhs-steps-up-winter-plans-and-calls-on-public-to-get-in-the-know/.

[40] Simon Paul Conroy et al., 'A Controlled Evaluation of Comprehensive Geriatric Assessment in the Emergency Department: The "Emergency Frailty Unit"', *Age and Ageing* 43, no. 1 (January 2014): 109–14, https://doi.org/10.1093/ageing/aft087.

[41] 'Statistics » Virtual Ward', accessed 7 March 2024, https://www.england.nhs.uk/statistics/statistical-work-areas/virtual-ward/.

from a narrow talent pool.[42] There is also some public doubt about the quality of care delivered through hospital-at-home programs.[43]

A systematic review and meta-analysis of 24 randomised clinical trials (two of which were UK-based) found that virtual wards are consistently associated with fewer A&E visits (mean of 17% fewer visits), shorter readmission stays (mean of -1.94 days), and therefore lower health care costs compared to hospital-based treatment.[44] However, the impact of virtual wards on health outcomes was inconsistent across disease areas. Whilst no study indicated worse outcomes compared to traditional ward-based care, fewer deaths and fewer readmissions were seen only in trials enrolling patients with heart failure, not COPD or other high risk patient populations.

A hospital-at-home service for frail patients, introduced by Frimley Health NHS Foundation Trust, led to 1,266 avoided admissions between April 2022 and March 2023. The service has evolved to include a 12-hour emergency community response, linked with 999. The hospital-at-home team is contacted by paramedics to attend patients who are confused or have had a fall. Referrals can also come directly from the patient, carer, GP, or social care.[45]

"*We received immediate care and attention and were informed of our loved one's condition with plenty of advice. In the past (he) has not received treatment like that in the hospital. Hospital at home every time*."

- Family member of a frail patient.

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[42] 'Realising the Potential of Virtual Wards | NHS Confederation', accessed 7 March 2024, https://www.nhsconfed.org/publications/realising-potential-virtual-wards.
[43] 'How Do the Public and NHS Staff Feel about Virtual Wards?', accessed 7 March 2024, https://www.health.org.uk/news-and-comment/charts-and-infographics/how-do-the-public-and-nhs-staff-feel-about-virtual-wards.
[44] Two of 24 studies are UK based. All are published in English; other geographies include: Australia, Canada, Netherlands, Singapore, Japan, Brazil, USA, Spain, Belgium, and Hong Kong. Source: Utkarsh Chauhan and Finlay A. McAlister, 'Comparison of Mortality and Hospital Readmissions Among Patients Receiving Virtual Ward Transitional Care vs Usual Postdischarge Care: A Systematic Review and Meta-Analysis', *JAMA Network Open* 5, no. 6 (28 June 2022): e2219113, https://doi.org/10.1001/jamanetworkopen.2022.19113.
[45] 'Frimley Frailty Community Response Service | NHS Confederation', accessed 13 May 2024, https://www.nhsconfed.org/case-studies/frimley-frailty-community-response-service.

Critical episode 3: deconditioning in hospital

Older people rapidly decondition in hospital. The trauma of suffering an acute illness or a fall, the stress of uncertainty, depletion of energy from bad food and disturbed sleep, deconditioning from lying in bed, can add up to "post-hospital syndrome".[46] In one study, almost a fifth of older people discharged from a hospital developed an acute medical problem within 30 days, which sent them back to hospital.[47] In only a third of cases was the cause of readmission the same as the original issue which had sent them there.

Doctors tend to focus on the illness which afflicted the patient in the first place. But the environment of the hospital also matters. Patients are often told to have "nil by mouth" for days on end, because procedures keep being postponed – with no alternative nutrition offered. Few seem to notice if they lose weight, though studies show this to be a strong predictor of readmission.[48] More imagination could be put into food procurement, and valuing the role of health care assistants in improving nutrition.[49]

Greater focus on deconditioning could be helped by producing a single new metric to balance "no criteria to reside". This is a key metric in acute hospitals, which is reported on every week. There is no corresponding metric which captures the long-term care and support needs of older people.

Evidence suggests that rehabilitation, or "reablement", can be more cost effective than conventional home care. An Australian study found that reablement delivers improvements in physical functioning compared to conventional homecare.[50] A UK

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[46] Krunholz, Harlan M M.D. (2013) Post-Hospital Syndrome – A Condition of Generalized Risk https://www.ncbi.nlm.nih.gov/ pmc/articles/PMC3688067/

[47] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med.* 2009;360:1418–28

[48] Friedmann JM, Jensen GL, Smiciklas-Wright H, McCamish MA. Predicting early nonelective hospital readmission in nutritionally compromised older adults. *Am J Clin Nutr.* 1997;65:1714–20

[49] Agnieska de Sousa, 'UK Labour's Starmer Vows £1.2B in Public Purchases of Local Food to Woo Farmers - Bloomberg', 20 February 2023, https://www.bloomberg.com/news/articles/2023-02-20/uk-labour-s-starmer-vows-1-2-billion-in-public-purchases-of-local-food?leadSource=uverify%20wall.

[50] Lewin, G. and Vandermeulen, S. (2010) 'A non-randomised controlled trial of the Home Independence Program (HIP): an Australian restorative programme for older home-care clients', Health & Social Care in the Community, vol 18, no 1, pp 91–99.

study found that reablement is associated with significantly better health-related quality of life and social care outcomes compared with conventional home care; and is probably more cost-effective.[51]

Shortages of OTs and physiotherapists pose a big challenge. As of the end of 2023, there were over 3,700 NHS vacancies for allied health professionals in England.[52] A search for "occupational therapist" on nhsJobs.com yields 936 job advertisements, many looking to fill multiple OT positions.[53]

"*We have two OTs and one physio for an 18-bed unit. Ideally, everyone would have a physio to help them get up every day and do exercises. But this takes 45-60 minutes. So realistically the physio only sees 5-6 people per day.*"

- Interviewee on Elderly Medicine Ward.

OTs will not necessarily see every individual needing help - in one study OTs saw only 30% of users[54]. But they play an important role in training and supporting care workers.

As the NHS tries to train and recruit more OTs, there could be a parallel push to contract with self-employed physiotherapists, (there is a national shortage of OTs, but not a shortage of trained physiotherapists outside of the NHS); and also to make greater use of personalised videos and (perhaps) VR.

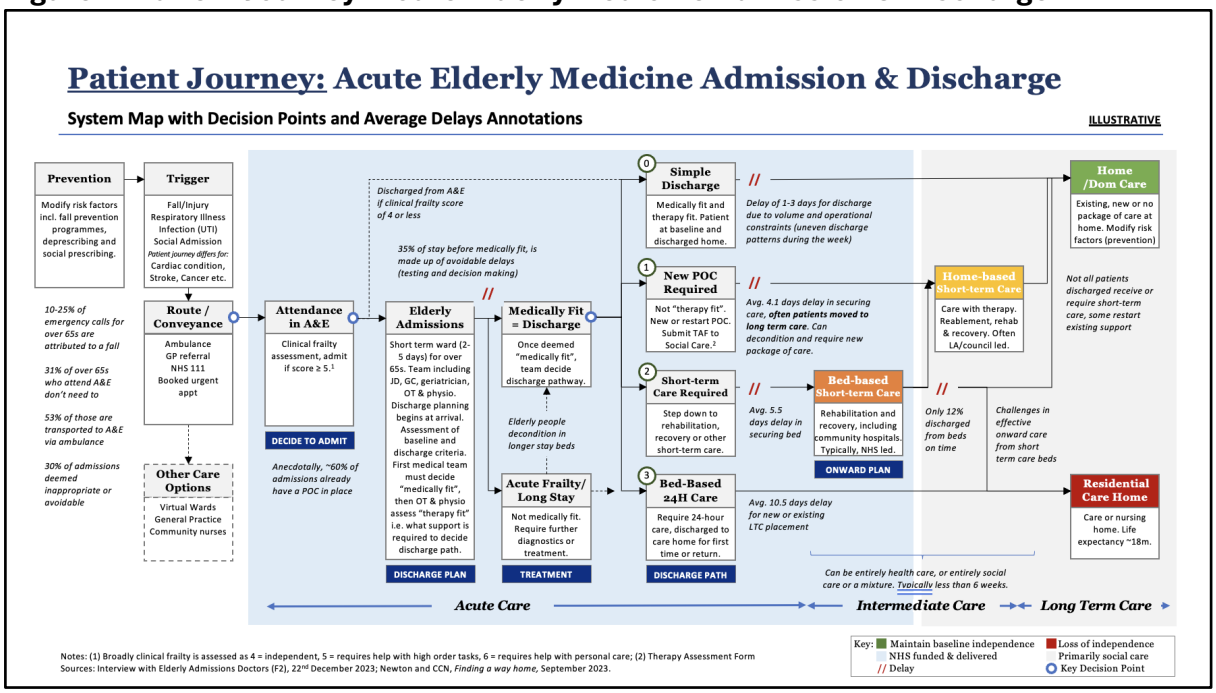
[51] Glendinning, C., Jones, K., Baxter, K., Rabiee, P., Curtis, L.A., Wilde, A., Arksey, H. and Forder, J.E. (2010) Home care re-ablement services: Investigating the longer-term impacts (prospective longitudinal study), York and Canterbury: Social Policy Research Unit and Personal Social Services Research Unit.
[52] Allied Health Professionals includes physiotherapists, occupational therapists, diagnostic radiographer, paramedic, podiatrist, orthopist, orthotist, and therapeutic radiographer. 'NHS Vacancy Statistics (and Previous NHS Vacancies Survey)', NHS England Digital, accessed 19 May 2024, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey.
[53] 'NHSJobs.Com: Occupational Therapy Vacancies | Trac.Jobs', accessed 19 May 2024, https://www.nhsjobs.com/job_list/Allied_Health_Professions/s4/Occupational_Therapy/d514?_ts=32677&_pg=19&_pgid=.
[54] Jones, K.C. (2009) Investigating the longer term impact of home care re-ablement services: The short-term outcomes and costs of home care re-ablement services: Interim report: Working Paper number DHR 2378, York and Canterbury: Social Policy Research Unit and Personal Social Services Research Unit.

Greater awareness of the risks of deconditioning has in itself been shown to drive improvement on the wards. In 2021-22, a British Geriatrics Society "(de)Conditioning Games" campaign in the East of England led to a reduction in falls at Northampton General Hospital, improved nutritional care in Norfolk and Norwich University Hospital, and improved confidence in the older people wards at Luton and Dunstable and Cambridge University hospitals, with no increase in care needs on discharge.[55]

[55] 'NHS England » Recondition the Nation'.

Critical episode 4: delayed discharge

Figure 2: Patient Journey: Acute Elderly Medicine Admission & Discharge



Delayed transfers of care endanger older people's chances of regaining independence for all of the reasons set out above: disorientation, loss of muscle mass, institutionalisation, and loss of confidence.

The most recent NHSE discharge data shows a daily mean of 21,566 patients with no criteria to reside, waiting for discharge, in April 2024.[56] It attributes 17.8% of the delays over 14 days to delayed residential care placements, and 24.0% to community rehabilitation beds. Both the NHS and ASC can do more to speed up discharge.

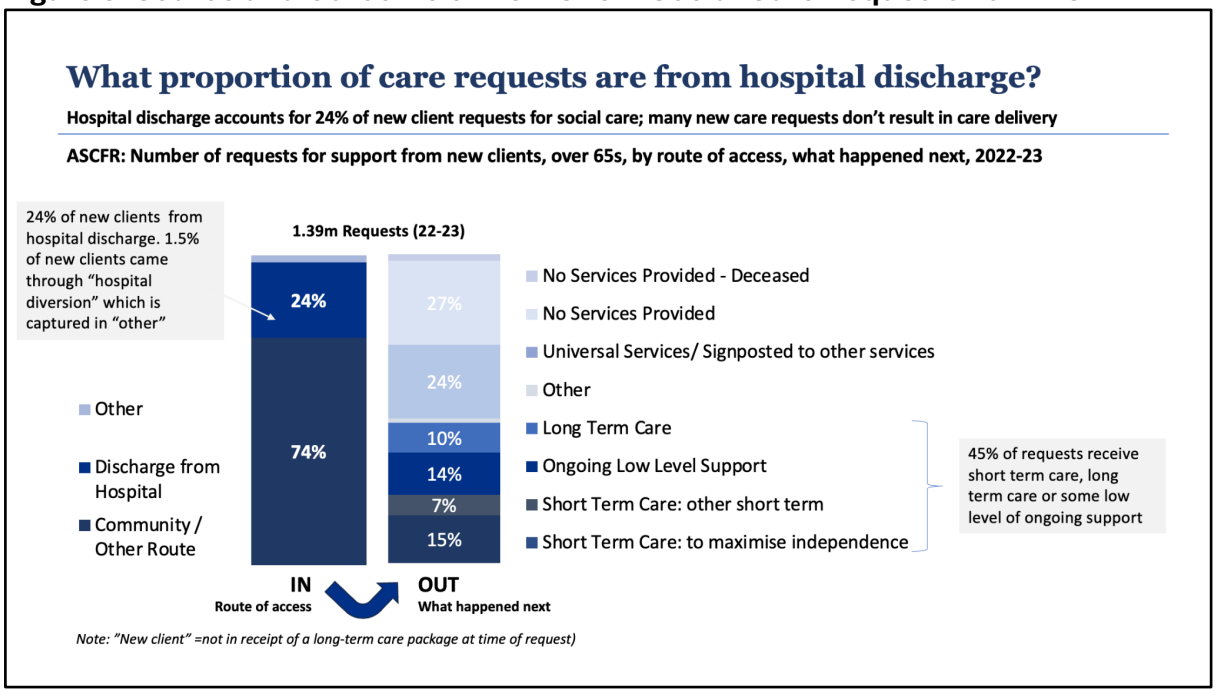
There are four hospital discharge pathways:

- Pathway 0: Simple discharge home; no new or additional support required.
- Pathway 1: Return home with a new, additional, or restarted package of support.
- Pathway 2: Discharged to a 24-hour bed-based setting for short-term care.
- Pathway 3: Discharged to a 24-hour bed-based setting for long-term care.

[56] NHS England, 'Statistics » Discharge Delays (Acute)', accessed 7 May 2024, https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays-acute-data/.

Simple discharges on Pathway 0 present an opportunity which the NHS alone can solve, without social care. Around 1 million bed days a year are lost to people going home without extra support, partly because discharge rates fall at weekends. The average 65+ patient is delayed by between 1 and 3 days when going home without any extra support.[57] Analysis by Newton and the County Councils Network finds that 35% of an acute stay before a patient is deemed "medically fit" for discharge is made up of avoidable delays, largely due to late diagnostic tests and delayed decision-making.[58]

Figure 3: Source and Outcome of New Client Social Care Requests 2022/23



Source: 'Adult Social Care Activity and Finance Report', NHS Digital, accessed 6 March 2024, https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report.

The other 3 Pathways involve both the NHS and ASC. For Pathway 1, Newton and CCN find an average delay of 4.1 days which equates to a cost of £176m. For Pathway 2, an average of 5.5 days, costing £120m. And for Pathway 3, 10.5 days, costing £160m. Our own analysis of these figures suggest they may even underestimate the opportunity since the calculations are built off Type 1 & 2 emergency admissions only, and do not

[57] CCN and Newton, "Finding A Way Home", 2023

[58] 'Newton and CCN - Finding a Way Home for Website', County Councils Network, accessed 7 March 2024, https://www.countycouncilsnetwork.org.uk/new-report-sets-out-how-hospital-admissions-can-be-avoided-and-how-patient-flow-can-be-improved-ahead-of-busy-winter-period/newton-and-ccn-finding-a-way-home-for-website/.

include bed days lost to deconditioning, which anecdotally are 3.5 times higher than the discharge delays reported.

When a patient is ready for discharge but remains on the ward, they are at risk of developing infections, bed sores, and other health issues. If they contract an illness, such as a urinary tract infection (UTI), they may need antibiotics and additional medical treatments, creating a new "criteria to reside" in the hospital. This extended inpatient stay is not accounted for in discharge delay reports, which only track delays from the latest "medically fit" decision to discharge. Anecdotal evidence from trusts that measure the total delay, including treatment for additional illnesses contracted while awaiting discharge, indicates that the number of bed days lost is approximately 3.5 times higher.

In theory, discharge planning begins as soon as a patient is admitted; it is ward-led by the care transfer hub or integrated discharge team. The gold standard is to carry out a multidisciplinary geriatric assessment as early as possible. But this can take days, because no one has the contact details of existing carers and relatives, or can't reach them. There is much talk of an "integrated MDT" approach, but the reality is often frustration from care agencies that wards lack understanding of a patient's prior physical abilities before admission.

"I think discharges could be improved if information about previous abilities, support, and living arrangements was available to and understood by wards, and they anticipated sooner that people may need more support, equipment, or a different setting to live in. They'll phone up and want to discharge someone and assume we can immediately provide the level of care needed and all the equipment. We can't and that leads to a delay."
- Care Agency, Cumbria.

Discharge teams would benefit from having a carer or "trusted assessor" on the team; staff who are trained to assess people and their home environment for home

adaptations in simple cases - and refer to occupational therapists as appropriate. The trusted assessor model is based on the principle that long-term care assessments should not take place in the hospital. They seem to work best when co-designed with all parties, including the local authority, HIAs and assessment teams.[59]

In addition to lack of information, there is no financial incentive for ASC providers to accommodate care requests quickly.

"To change the rostering of carers, so that they can accommodate another individual, it's operationally taxing and a lot of friction, so they just don't do it"
- Care Provider

One answer could be to pay providers a small bonus – as some LAs are now doing – for accommodating care requests within 24 hours.

While discharge Multi-Disciplinary Teams (MDTs) operate across health and social care, they often do not function as a cohesive unit. Currently, data sharing is done manually using Excel spreadsheets, and updates are communicated verbally during twice-daily meetings. Only an estimated 10-20% of NHS Trusts and Adult Social Care (ASC) services have some form of IT integration.[60] But then - it was only in November 2023 that we reached a 90% threshold of trusts using electronic patient records.[61]

Much could be gained by making it easier for MDTs to collaborate. This is a key function of OPTICA, a core product of the NHS's Federated Data Platform (FDP), which stands for 'Optimised Patient Tracking and Intelligent Choices Application'. The first version,

[59] 'Trusted Assessors | Local Government Association', accessed 13 May 2024, https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/trusted-assessors.
[60] Estimate based off known FDP adoption, published Discharge Frontrunners proposals, and interviews.
[61] '90% of NHS Trusts Now Have Electronic Patient Records', NHS Digital, accessed 10 March 2024, https://digital.nhs.uk/news/2023/90-of-nhs-trusts-now-have-electronic-patient-records.

OPTICA Acute, is designed to improve patient discharge processes by tracking discharge-related tasks in real-time and enabling effective decision-making.[62]

Provided a data sharing agreement (DSA) is in place, OPTICA allows local authorities to access NHS trust data, either in a secure read-only or editable capacity. This access to essential discharge information enables multi-agency teams to plan and coordinate discharges together for example enabling local authorities to see upcoming care package requests and which discharge tasks will impact on the planned discharge date. Acute hospitals can also access local authority data to help establish existing care needs at admission, however, this invariably requires local authorities to provide data flows, usually via their third-party vendors, who charge for building new data channels and this can be prohibitive. Reimbursing local authorities for this cost could quickly unblock the information flow.

OPTICA does not replace the Electronic Health Record (EHR) system or store medical data. It can be customized to each NHS trust's needs, with locally defined codes mapped to national codes, making it easily configurable to track desired metrics. During its pilot, OPTICA reduced delay days for long-term stays (21+ days) by 36% and freed up 9.5 hours of clinical staff time per week.[63] OPTICA is now live in 20 acute hospitals and was developed by NECS (North of England Care System Support, part of Palantir's consortium) and incubated at North Tees & Hartlepool Foundation Trust, going live in April 2022.

[62] 'NHS England » New Data-Led Solution Reduces Delays to Patient Discharges', accessed 7 March 2024, https://www.england.nhs.uk/long-read/new-data-led-solution-reduces-delays-to-patient-discharges/.
[63] 'NHS England » New Data-Led Solution Reduces Delays to Patient Discharges', accessed 6 March 2024, https://www.england.nhs.uk/long-read/new-data-led-solution-reduces-delays-to-patient-discharges/.

Federated Data Platform (FDP) Context:

The NHSE/Palantir contract in March 2020 launched their data management platform (Foundry) as a Covid-19 data store for the UK. This provided a "single" and "shared version of the truth" about the rapidly evolving Covid situation and allowed decision-makers to use accurate real-time metrics to make informed decisions.[64]

The FDP is an evolution of the Foundry platform, with privacy-enhanced technology (PET). It is an operational layer that sits on top of existing data stores, such as Electronic Health Records (EHRs), to make it easier to share data. It does not change what data is collected or how it is stored.

To share health data in the UK, it is a legal requirement to have a Data Sharing Agreement (DSA) in place – whether sharing with the local GP or NHS England. Each organisation is the controller of their own data (in England – Scotland has made GPs co-data controllers with the NHS) and data sharing is not automatic with the FDP; a DSA will still be required to share data.[65]

In addition to data-sharing capabilities, the FDP provides access to products or applications to improve operations. The FDP product pipeline is segmented into five verticals: Population Health, Care Coordination, Supply Chain, Vaccination & Immunisation, and Elective Recovery.[66] Products are incubated in one NHS trust, and then rolled out to others through the FDP.

In November 2023, a £480m contract (to be paid over seven years) was awarded to a consortium led by Palantir. While unpopular with some campaigners and the BMA, the landscape has changed since the care.dot.data fiasco. Covid-19 dashboards

[64] Gavin Freeguard and Paul Shepley, 'NHS Covid-19 Data Store and NHS National Data Platform', n.d.
[65] 'NHS England » Federated Data Platform', accessed 10 March 2024, https://www.england.nhs.uk/digitaltechnology/digitising-connecting-and-transforming-health-and-care/.
[66] 'NHS England » Federated Data Platform – Improving and Connecting Our Health Information', accessed 10 March 2024, https://www.england.nhs.uk/long-read/federated-data-platform-improving-and-connecting-our-health-information/.

have demonstrated the value of an integrated data system; the NHS has made it a strategic priority to give patients access to their data through the NHS App; and the government has reiterated the importance of privacy-enhanced technology (PET) for the FDP.[67] The FDP allows for opt-out, in compliance with the existing national opt-out policy. Yet according to meeting notes from 'FDP Check and Challenge Group', on 15th December 2023, opt-out for the FDP is "significantly lower" than the GDPR – a pseudonymized database from GP medical records used for research.

NHSE has made Foundry/FDP free for Trusts to adopt. Yet so far, only about 20% of NHS trusts (42 trusts) and 2 ICSs (North West London and Sussex) use Foundry; they are set to migrate to the Federated Data Platform (FDP) over the next few months. To encourage adoption of the FDP we need greater clarity on information governance practices.

When North Tees & Hartlepool FT piloted OPTICA it took 8 months to agree information governance and only 4 months to build OPTICA. While this is probably the worst case (OPTICA was new, Foundry was new, trust issues, etc), a robust IG Framework is now in place across the FDP though IG issues could still cause delays in adopting the FDP and building new products on it. A November 24th 2023 NHSE meeting minutes of a 'Federated Data Platform Check and Challenge Group' suggests there is a need to create more detailed patient opt-out guidance for IG leads in the FDP Information Governance framework which is being developed.[68]

Another challenge is communicating the value of the FDP and core products to ICSs, Trusts and LAs; this takes time. The FDP and OPTICA are free for Trusts to adopt (funded by NHSE); despite this, Sussex ICS was awarded additional NHSE funding in January 2023 to build a 'business information tool' with similar product features to

[67] 'NHS England » Millions More People given Access to Their GP Records Online', accessed 10 March 2024, https://www.england.nhs.uk/2023/12/millions-more-people-given-access-to-their-gp-records-online/.
[68] 'NHS England » Federated Data Platform Check and Challenge Group – Minutes and Action Notes: 24 November 2023', accessed 10 March 2024, https://www.england.nhs.uk/long-read/fdp-check-and-challenge-group-minutes-24-november-2023/.

OPTICA.[69] Other ICSs and LAs have procured similar solutions to OPTICA from third parties. It is inefficient for NHSE to fund the development of multiple products with the same capabilities, and for LAs to spend on products that are free to adopt.

The adoption of the FDP, and OPTICA, needs to be accelerated through incentives, or potentially mandates. Options include eliminating NHSE funding for duplicative products, publishing FDP adoption figures, removing cost barriers for LAs to share data, promoting benefits to staff (e.g. clinical time saved), expanding OPTICA to other MDTs, or mandating FDP adoption.

Critical episode 5: when temporary intermediate care becomes permanent

The right kind of rehabilitation gives the best chance of bouncing back to a more fulfilling life, and less reliance on others. Effective intermediate care can support two thirds of people to return home, according to a US study.[70] In an analysis co-produced by Newton and County Councils Network (CCN), found that across 11 different local authorities, the average amount of long-term care and support required after a short-term reablement intervention was £8700 cheaper than if the individual had not received reablement support. This equates to a seven times return on investment for reablement.[71] If representative of other local authorities, this would represent an astonishingly good return on investment.

The principles of intermediate care are embedded in the 2014 Care Act and in guidance from the National Institute of Care Excellent and SCIE.[72] But the provision of intermediate care is patchy, and not as effective as it could be. New figures suggest,

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[69]Part of the Discharge Frontrunner Program, which includes Sussex ICS, Humber and North Yorkshire ICS, Four Localities Partnership, One Croydon Alliance, Leeds Health and Care Partnership, Warwickshire Place; 'Accelerating Patient Flow through, and Discharge from, Hospitals', n.d.

[70] John Young et al., *Measuring and Optimising the Efficiency of Community Hospital Inpatient Care for Older People: The MoCHA Mixed-Methods Study*, Health Services and Delivery Research (Southampton (UK): NIHR Journals Library, 2020), http://www.ncbi.nlm.nih.gov/books/NBK552324/.

[71] 'CCN – The Future of Adult Social Care', accessed 6 March 2024, https://www.futureasc.com/.

[72] National Institute for Health and Care Excellence, 'Promoting Independence through Intermediate Care: A Quick Guide for Staff Delivering Care Services', 2018, https://www.nice.org.uk/Media/Default/About/NICE-Communities/Social-care/quick-guides/promoting-independence-through-intermediate-care.pdf.

worryingly, that even more people are being discharged from hospital straight into residential or nursing care.[73]

Intermediate care is provided free for up to 6 weeks, funded by the NHS and local authorities (through the Better Care Fund). There are four types of intermediate care. Whilst intermediate care is both "step up" care to prevent hospital admission and "step down" following a discharge, the first three types more commonly serve the latter:

1. **[Pathway 1] Reablement intermediate care** (typically 1-2 weeks): home-based to regain confidence/independence. 'Doing with' approach.
2. **[Pathway 1] Home-based intermediate care:** provides support in home, typically delivered by health professionals (nurses, physio, OT etc.)
3. **[Pathway 2] Bed-based intermediate care:** temporary stay in a care home, community hospital, or standalone IC facility.
4. **[Prevent Admission] Crisis response intermediate care**: typically, step-up to prevent hospital admission, short-term care at home or care home.

The latest figures from the Adult Social Care Outcomes Framework (ASCOF) indicate that 2.9% of over-65s are offered short-term care to maximise independence following a hospital stay (Oct-Dec 2022). The denominator includes all admissions, planned and unplanned. Of the patients offered short-term care, 82.3% continue to reside at home 91 days later. However, there is significant variation by council - both in proportion to offered short-term care and the quality of intervention - six of the top 10 performing councils are in London.[74] Newton and CCN estimate that 40,000 additional older people could benefit from home-based reablement if capacity was increased.[75]

[73] 'Adult Social Care Activity and Finance Report', NHS Digital, accessed 6 March 2024, https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report.
[74] 'Measures from the Adult Social Care Outcomes Framework, England, 2022-23', NHS Digital, accessed 7 March 2024, https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2022-23.
[75] 'Newton and CCN - Finding a Way Home for Website'.

While NHS Digital's Adult Social Care Outcomes Framework (ASCOF) provides valuable metrics for assessing the effectiveness of reablement programs, there are persistent issues with data quality. The fragmentation of care delivery, lack of standardised data collection methods, and low levels of system integration often result in unreliable data. Alongside expanding the ASCOF and introducing new care metrics (which are often dwarfed by NHS waiting lists and discharge delay scenarios), we must also address these data quality challenges. In addition, new metrics should consider potential unintended consequences, for example, if providers are assessed on criteria 'continue to reside at home' metrics for reablement services, then they may reject high-risk patients.

A carer that the older person already knows, and trusts, can be very effective in re-abling. But getting people back onto their feet requires a very different mindset from much traditional health and care work. It is characterised by "doing with", rather than "doing to": helping people to regain confidence with mobility, to make their own food and drink, personal care, do housework, maintain social contact. Some carers report difficulty switching between traditional caregiving work and reablement work.

"All carers are told they must promote independence but I'm not clear that the majority of carers truly understand what this means. It isn't just standing back and telling people to do things for themselves. Reablement visits take time and local authorities allocate people the shortest time possible for calls. For example, if you were supporting someone to become more independent in making meals, then promoting this at a lunch visit where they are prompted and encouraged by the carer at each step is likely to take a lot longer than the carer simply doing it for them".

- Dawn, professional carer

In Leicestershire, and at the One Croydon Alliance, OTs and physios have trained carers in making this mindset change to reablement work. There are no standardised entry requirements to become a reablement worker, though most employers prefer workers with existing care experience. Training is on the job with optional e-learning modules,

which take between 90 minutes and three hours to complete. Part of reablement is psychological.

"Recognising the role loneliness, isolation and boredom plays in demotivating people and lowering their mood and trying to address this in reablement programmes would be helpful. There is still a dated approach to this - the standard offer is a day centre, lunch club or befriending services and while these are valuable resources perhaps we could now be looking at newer technology and how we can connect people through the internet and providing them with a tablet or laptop and a few lessons in how to use these to reduce isolation and access games or reading". Dawn, professional carer

A more holistic approach to care transitions back home seem to be effective. Examples include the One Croydon Alliance, one of the NHSE's "Discharge Frontrunners".[76] Its 7-day 'wraparound service' after discharge has 95.9% of over-65s still at home 91 days after short-term care.[77] The team ensures the patient has the relevant medication and equipment, a care assessment and care needs met within the week.[78] Meanwhile, Northamptonshire has approximately doubled the number of older people returning to their homes from hospital, to 50-60% of individuals returning home, by converting a former council-run care home into a Recovering Independence Beds unit staffed by nurses, therapists, and care workers.[79]

In 2022/23, nearly 200,000 over 65s received short-term care to maximise independence.[80] Of the 200,000, 19% were then referred to a long-term care service and 9% to another short-term care service. If short-term beds are commissioned just to improve flow in the acute hospital, without planning for the onward care needs of

[76] Anne Booth, 'A New Community Rehabilitation and Reablement Model', 2023.
[77] 'Measures from the Adult Social Care Outcomes Framework, England, 2022-23', NHS Digital, accessed 7 March 2024, https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2022-23.
[78] 'Intermediate-Care-One-Croydon-Case-Study-October-2023.Pdf', accessed 7 March 2024, https://careprovideralliance.org.uk/assets/pdfs/intermediate-care-one-croydon-case-study-october-2023.pdf.
[79] 'Newton and CCN - Finding a Way Home for Website'.
[80] 'Adult Social Care Activity and Finance Report'. Table T21.

patients, we will just have a new form of bed-blocking. An analysis published in the HSJ in September 2023 highlighted this risk.[81]

In January 2023, the government gave an additional £200m to ICBs, to reduce the number of patients who did not meet the criteria to reside in acute hospitals but continued to do so. The primary focus of this funding was for local NHS bodies to buy residential care beds to increase capacity in post-discharge care and support. But mostly what seems to have happened is that short-term beds were bought without sufficient therapy or reablement support, thus turning patients who could have recovered into people who are now heading for residential care.

In Leicestershire, Leicester City, and Rutland, analysis suggested that older people were being discharged into short-term beds in residential care and staying in those settings long-term. When therapy staff were introduced to help guide the recovery programmes, 77% of patients were able to return to their own homes – most with either no further care or a reduced package of care than had previously been anticipated.[82]

The lesson here is for DHSC to direct future crisis winter funding to ICS and to require assurances that there will be sufficient therapy staff available.

How might domiciliary care agencies and care homes be incentivised to get people back on their feet, rather than increase dependency? Some want to promote independence as part of their ethos. But for many, the financial incentive is the opposite. Some local authorities have achieved this by reassuring their partner care agencies that they will supply a new client at the end of each contract. This is easiest to do in places where demand outstrips supply, and where LAs have preferred partners.

[81] Health Service Journal. (7 September 2023). Community discharge delays much worse than acutes. https://hsj.cdn. wilmingtonplc.com/2023/09/07/community-discharge-delaysmuch-worse-than-acutes/content.html

[82] 'Newton and CCN - Finding a Way Home for Website'.

2. Using data & technology to improve outcomes for older people

Recommendation:

Accelerate the digitisation of health and care records, promote data-sharing and technology to reduce frontline workloads and improve the integration of health and care

Technology will never be a complete substitute for the kind of empowering human interaction outlined in this paper. Some older people struggle to use smartphone apps, some have cognitive impairment, and many prefer face-to-face appointments to remote ones. But used wisely, digitisation and technology offer a transformative opportunity to improve health and care outcomes, lower the unit cost of care delivery, and reduce the time that frontline staff spend on paperwork.

The average care professional can spend over five hours a week on administration.[83] This is partly because so many different organisations require data returns: including local authorities, the DHSC (via Capacity Tracker), and the CQC (Provider Information Returns). Some care workers are having to return to the office in between visits, to log information manually.

Digitisation should dramatically simplify these processes. Beyond that lie digital solutions such as electronic medications management, incident monitoring, rostering, and financial accounting. Birdie, a home care management solution on the DHSC assured solution list for domiciliary care providers, claims that 73% of carers using it save between 7-15 hours a week on day-to-day operations.[84] In an independent evaluation of Procomp (a Finnish company in workforce utilisation and logistical planning), commissioned by Health Innovation West of England, Procomp

[83] 'Saving Time with Birdie | Birdie Blog', accessed 9 April 2024, https://www.birdie.care/blog/save-time-birdie.
[84] 'Birdie | All-In-One Homecare Software | Built as One', accessed 6 April 2024, https://www.birdie.care/.

demonstrated a 4.0% reduction in carer travel distance at one site and 7.8% at another: this meant that fewer appointments were cut short and care workers reported higher job satisfaction.[85]

Beyond the back office, consumer tech and data analytics offer improved outcomes by reducing loneliness, early detection of risks, better post-acute recovery and reconditioning, and letting more people die at home: the wish expressed by a majority of the public.[86]

The NHS has made digitisation a national priority, reaching 90% coverage of electronic health records.[87] Progress is also being made towards the join-up of primary and secondary care. Extending these advances to social care could end the disjointed transitions that patients experience between health and care. High quality data is also essential if the government is to be able to assess how well local authorities and ICSs are supporting their over-65 populations, and to help both carers and users make more informed choices.

"The core functionality of a DSCR can transform the way a provider operates, but there's a lot more features that can be switched on over time. Soon, all of our assured digital social care record suppliers will be required to integrate with GP Connect, which gives care staff 24-hour access to vital health information for the people in their care, such as medications or allergies. One provider I met recently described it as 'game-changing' for them, drastically reducing the amount of time spent on the phone to GPs and hospitals trying to track down information".

-Alice Ainsworth, Deputy Director for Social Care Technology, DHSC.[88]

[85] 'Domiciliary-Care-Workforce-Programme-Evaluation-Final-Report.Pdf', accessed 20 May 2024, https://www.healthinnowest.net/wp-content/uploads/2024/04/Domiciliary-Care-Workforce-Programme-Evaluation-Final-Report.pdf.
[86] 'National Survey of Bereaved People (VOICES) - Office for National Statistics', accessed 20 May 2024, https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/2014-07-10.
[87] '90% of NHS Trusts Now Have Electronic Patient Records', NHS Digital, accessed 10 March 2024, https://digital.nhs.uk/news/2023/90-of-nhs-trusts-now-have-electronic-patient-records.
[88] 'Unlocking the Benefits of Digital in Care | Digitising Social Care', accessed 20 May 2024, https://beta.digitisingsocialcare.co.uk/.

The current state of technology and data in ASC and the NHS

1. Digitisation.

The government has made the digitisation of the NHS a national priority. In November 2023, NHS England met the government's target for 90% of trusts to adopt electronic patient records (EPR/EHR); the remaining 10% are in live procurement processes.[89] However, there is further to go. The Digital Maturity Assessment programme suggests that just 10-30% have additional functionality such as integrated prescriptions and record sharing capabilities.[90] This reflects the time it takes to procure new products, interoperability challenges, and competing priorities.

Social care is even further behind. Covid-19 exposed the inadequate data collection and poor data quality in ASC. In 2021, the DHSC estimated that only about 40% of providers had a digital social care record (DSCR), and that only 39% of providers were compliant with the most basic level of cyber security. Around 62% of care homes did not have a reliable internet connection.[91]

DHSC's 'Digitising Social Care' (DiSC) programme has made some headway since. Launched in April 2022, its budget of £150 million over three years has funded ICBs to (a) help care providers to offset the implementation cost of DSCRs and (b) run pilots and scale-up technologies, including falls prevention and remote monitoring technologies. The programme also funds a technical role at each ICB to coordinate support for local providers and can help shortlist appropriate suppliers from the DHSC's assured solution list for DSCR.[92] Insights from interviews suggest that the ICBs

[89] '90% of NHS Trusts Now Have Electronic Patient Records', NHS Digital, accessed 10 March 2024, https://digital.nhs.uk/news/2023/90-of-nhs-trusts-now-have-electronic-patient-records.
[90] 'DMA Results Show Only 10-30% of Trusts with an EPR Have Key Functionality', *Digital Health* (blog), 12 December 2023, https://www.digitalhealth.net/2023/12/dma-results-show-only-10-30-of-trusts-with-an-epr-have-key-functionality/.
[91] 'People at the Heart of Care: Adult Social Care Reform White Paper', GOV.UK, 18 March 2022, https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper.
[92] There are currently 26 companies listed on DHSC's assured solution list. This is subject to change to 10-15 providers, as those that are no longer compliant with standards are removed. DHSC, 'Next Steps to Put People at the Heart of Care' (Department of Health and Social Care, 4 April 2023), https://www.gov.uk/government/publications/adult-social-care-system-reform-next-steps-to-put-people-at-the-heart-of-care/next-steps-to-put-people-at-the-heart-of-care.

which have been most successful have taken a cohort approach, getting care providers to work together and share recommendations.

Now in the third year of the programme, the latest published government statistics show that care provider uptake of DSCRs has increased to approximately 63%, which DiSC estimate covers around 70% of people receiving care in England**.** Our interviews suggest that the pipeline of providers in contact with suppliers increases this significantly. This is still below the initial 2022 target of 80% by March 2024. But the high churn of care providers and the long tail of small providers makes it unlikely that 100% will be achieved.

The results of the care technology pilots which began in 2022 are not yet available. Anecdotally, some were highly successful, including Nobi, which reduced falls by 85% in one home, piloted in Lancashire and South Cumbria ICB.

Going forward, there needs to be a systematic sharing of evidence across ICBs and a further commitment to multi-year funding for DiSC.

2. **Workforce – Digital skills**

The care sector lags the NHS in terms of staff skills. The NHSX's *Adult Social Care Technology and Digital Skills Review (2021)* found that a significant proportion of the social care workforce do not feel confident using digital technology, with 27% classified as being at "pre-novice" level. Managers reported that only 37% of staff operate digital devices as part of their job, and only 35% of care staff are supporting care recipients to use technology.[93]

This matters, because innovative technologies will not work without adequate organisational, clinical, and technological infrastructure to support staff who use them.

[93] NHS Transformation Directorate, 'Adult Social Care Technology Innovation and Digital Skills Reviews', NHS Transformation Directorate, 1 December 2021, https://transform.england.nhs.uk/key-tools-and-info/adult-social-care-digital-transformation/adult-social-care-technology-innovation-and-digital-skills-reviews/.

On the frontline, staff may need to be comfortable with operating iPads to share information, or using VR headsets to train. In the back office, care providers need information governance skills.

Learning digital skills may improve the job satisfaction of care workers. A pilot in East London by Care City, a Community Interest Company, trained domiciliary care staff to become 'Expert Carers', with remote monitoring kits to undertake regular monitoring of the vital signs of those in their care.[94] The pilot found growth in both the skills and confidence of care staff, and a sense of improved status among service users and their families. Staff felt that the quality of their care had improved, and believed that those they supported felt this too.

The DiSC Digital Skills Framework (launched May 2023) is an attempt to set out which digital skills staff need, with a database of training providers and bite-size e-learning videos. Skills for Care is developing 8 eLearning modules to train digital champions and is co-developing a digital leadership qualification with The National Care Forum. Long-term clarity is needed over training budgets.

3. Data Interoperability

The number of unique information systems, few of which are interoperable, is a major challenge for using data efficiently, joining up services and serving patients well. Adult social care suffers less from this problem than the NHS, to the extent that it has less legacy technology. But it is even more fragmented.

DHSC has scheduled formal procurement of an interoperability platform in April 2025. This will be a middleware to share data and provide data at scale, letting care providers connect to one platform to share data in real-time with stakeholders.

[94] Camille Oung et al., 'Developing the Digital Skills of the Social Care Workforce' (Nuffield Trust, 30 September 2021), https://www.nuffieldtrust.org.uk/research/developing-the-digital-skills-of-the-social-care-workforce.

It will be important that the ASC interoperability platform connects to DSCRs and be able to accommodate future care technologies (including wearables and sensors). It will also be important to standardise consent language and reduce any administrative barriers for data sharing (while respecting legal restrictions and data sharing agreements). DHSC plans to take snapshots of the aggregated data for longitudinal analysis and generate synthetic data to train AI models.

4. **Procurement & Incentives**

Procurement of technology is highly decentralised. There are 216 NHS trusts each procuring technology, and over 7,000 data controllers in the NHS.[95] Procurement is even more fragmented for ASC with around 18,000 provider organisations. The result is an inconsistent standard, duplicative processes, and waste.

With contracts coming up for renewal at different times, and in-flight procurement processes, it will take time to converge technology solutions. Dr Tim Ferris, the NHS' first National Director of Transformation 2021-23, introduced the concept of "managed convergence" in February 2022. The idea was to encourage ICSs to reduce the number of EPRs over time, across acute care, community services, mental health, ambulance services, primary care, and social care. This would provide critical, real-time access to all health-related information for caregivers. It would also enable more simplified access for patients to their own data."[96]

North West London ICB has committed to a consolidated procurement function with eight NHS trusts in its 'Stronger Together' transformation programme. This will unite a total expenditure of £6.4bn under North West London Procurement Services (NWLPS) management.

[95] Joe Zhang et al., 'Mapping and Evaluating National Data Flows: Transparency, Privacy, and Guiding Infrastructural Transformation', *The Lancet Digital Health* 5, no. 10 (1 October 2023): e737–48, https://doi.org/10.1016/S2589-7500(23)00157-7.
[96] 'Major Push on EPR "Convergence" and Levelling up from the Centre', accessed 25 March 2024, https://www.digitalhealth.net/2022/03/major-push-on-epr-convergence-and-levelling-up/.

"*When I joined in November 2021, there was no way of determining the total spend across the ICS, which included nine NHS organisations. Some trusts used three different enterprise resource planning (ERP) systems, and others didn't have any system to analyse procurement activity properly. If we were going to gain transparency over spending, we needed a comprehensive, integrated approach*."

-Lee Jackson, MD of NWLPS.[97]

The challenges faced in ASC are more nuanced: it is a (predominantly) private market, there is greater fragmentation of providers, and no clear pathway for cascading information to scale up technologies. There is also an asymmetry of benefit: technologies which help to reduce hospital admissions may be of greater marginal benefit to the local acute trust than to the individual care provider.

One way forward would be to take a system-level approach. Technologies with bottom line benefit to the NHS could be coordinated and funded through ICBs (via the DiSC budget). Anecdotally, what some ICBs have done in pilots (e.g. Lancashire & South Cumbria) is for the local authority to purchase the technology and then 'loan' it out to care homes, providing access to the data and analytics from the start, which enables system benefits to be measured in real-time. Going forward, the assured solutions list for care providers (which currently includes the 12 DSCR solutions) would be expanded to care technologies which have had successful pilots with ICSs.

For this to work there would need to be robust evidence of efficacy, with a framework to assess care technologies mirroring the NICE Evidence Standards Framework (ESF). Introduced in 2019, ESF offers a standardised method to evaluate the functionality and risks of digital health technologies (DHTs) like smartphone apps and software. The framework demands a higher standard of proof for technologies with higher risks. It also helps innovators by making the evaluation process transparent.

[97] 'Transforming NHS Procurement: How Good Data Holds the Key to Integrated Care', *Digital Health* (blog), 26 March 2024, https://www.digitalhealth.net/2024/03/transforming-nhs-procurement-how-good-data-holds-the-key-to-integrated-care/.

The ESF is designed to assess clinical outcomes for the NHS, not quality of life metrics for those in need of care. It excludes remote monitoring technologies and those which share information with carers or family members. None of the 104 DHT examples on NICE's website are designed for carers or care providers. Building a separate framework for social care is one option. It would be better, though, to expand the NICE evidence standards framework to care technologies. Many care technologies are health-related (monitoring hydration levels, medication management).

Building an evidence-base of system benefits would require an expansion of funding for care-related ICS pilots. The DiSC £150m budget includes the 'Supporting Independence Through Technology Fund' (£6m) and the 'Adult Social Care Technology Fund' (£6m). The latter has funded eight pilots, including a medication management system, virtual care model, pain management tool, video and communication devices, and a 4D mapping technology to track movement and detect falls.[98] Government should ensure that pilot outcomes and evidence are shared with other ICBs and the evidence-base of proven technologies should be made publicly available, to help private care agencies and self-funders avoid wasting money in what is likely to be a raucous marketplace. Acoustic monitoring has demonstrated a 20% reduction in hospitalisation, for example, whereas some electronic medication dispensers have been ineffective and difficult to use.

One question is whether the government should be funding the scale-up of the sector when there is so much churn in the market. If local authorities move towards partnership agreements with a few preferred providers, digital scale-up will be concentrated. But ICBs will need to address the information cascade to smaller providers, perhaps through the cohort programmes which are already showing results.

[98] 'Over £4 Million for Smart Tech to Improve Care, Support Independence and Reduce Hospital Admissions Announced | Digitising Social Care', 21 March 2024, https://digitalsocialcare.co.uk/news/4-million-smart-tech-improve-care-support-independence-and-reduce-hospital-admissions.

5. Cultural resistance to change

Doubts about technology remain widespread across all levels of the NHS and social care. Part of this is justified: there is a graveyard of failed tech interventions (notably, the dismantling of UK's National Programme for IT in 2011).[99] Staff also worry about patient privacy: one care worker told us that she and colleagues are having to share information with the GP via their personal phones, and then delete it.

We have heard anxiety from doctors that AI may replace them, and from care staff that digital technologies might replace face to face care, or switch their time away from clients. All of this requires clear communication from the top, to explain the changes.

Professionals are right to demand that new systems must be secure, and data used ethically. But the apparent reluctance of some acute trusts to adopt the FDP, and local authorities to use OPTICA, prevents MDTs adopting technology to facilitate collaboration – even when data sharing agreements are in place. The resistance of GPs in England to sharing health records, because of concerns about their legal liability, has slowed progress. NHS Scotland has resolved the problem by making GPs joint data controllers with their contracting Health Boards.[100] The same solution should be applied in England and Wales.

During the pandemic, joining up data saved lives. It led to the identification of four treatments for COVID-19, including dexamethasone, which has saved over a million lives worldwide through the Oxford Recovery trial. This was achieved because the DHSC issued a Control of Patient Information notice, which allowed COVID-19 researchers to access GP records.[101] If a similar approach were taken to other major

[99] Taghreed Justinia, 'The UK's National Programme for IT: Why Was It Dismantled?', *Health Services Management Research* 30, no. 1 (February 2017): 2–9, https://doi.org/10.1177/0951484816662492.
[100] Community Health & Social Care Directorate, 'Joint Controller and Information Sharing Agreement for Health Boards and GP Contractors' (The Scottish Government, 27 November 2019), https://www.publications.scot.nhs.uk/files/pca2019-m-15.pdf.
[101] 'Control of Patient Information (COPI) Notice', NHS England Digital, 15 February 2022, https://digital.nhs.uk/coronavirus/coronavirus-covid-19-response-information-governance-hub/control-of-patient-information-copi-notice.

diseases, this could enable researchers to make potentially even more important breakthroughs. For example, joining up data in Denmark (6.2 million patient records) has allowed researchers to develop a deep learning algorithm to identify people at the highest risk for pancreatic cancer (a very aggressive disease, with a 5-year 12% survival rate) up to three years before diagnosis (2023).[102]

6. Failure to design for older people

Alongside the widespread assumption in health care that older people don't want choice and control, there is a pervasive belief that the over-65s are not tech savvy. This means that too often older people are an afterthought when new technologies are designed.[103] But there is in fact a wide range of abilities and levels of willingness to engage with new technologies.

Active grandparents, married couples, the well-off and the highly educated are most likely to use the internet and technology. In 2020, 85.5% of UK 65- to 74-year-olds and 54.0% of over 75s had used the internet in the previous three months, up from 61.1% and 29.1%, respectively in 2013; a surge in usage which will probably continue.[104] In 2023, a study published in BMC Geriatrics found that more than 52% of those aged 65 and over were willing to use health-apps. Functions and features most cited as useful by older populations included symptom self-monitoring and surgery recovery assistance.[105]

It would be wrong, however, to overlook the group which is struggling. Around 34% of people aged 75 & older do not use the internet (2023).[106] Such people are more likely to

[102] Davide Placido et al., 'A Deep Learning Algorithm to Predict Risk of Pancreatic Cancer from Disease Trajectories', *Nature Medicine* 29, no. 5 (May 2023): 1113–22, https://doi.org/10.1038/s41591-023-02332-5.
[103] Ryan A Mace, Meghan K Mattos, and Ana-Maria Vranceanu, 'Older Adults Can Use Technology: Why Healthcare Professionals Must Overcome Ageism in Digital Health', *Translational Behavioral Medicine*, 8 September 2022, ibac070, https://doi.org/10.1093/tbm/ibac070.
[104] 'Internet Users - Office for National Statistics', accessed 26 March 2024, https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/datasets/internetusers.
[105] https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-023-03772-x#:~:text=Results,willing%20to%20use%20health%2Dapps.
[106] 'Policy-Briefing---Facts-and-Figures-about-Digital-Inclusion-and-Older-People.Pdf', accessed 6 April 2024, https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-

be on a low income with less cash to buy devices; or to live alone, with no one to help them navigate. Many elderly people with declining cognitive function also need help to make appropriate decisions.

Struggling with technology is not always synonymous with being averse to it, however. The Alternative Futures Group, which supports 9,000 people in North West England, has created a tech lending library which lets people borrow and try out smartwatches, VR headsets and robotic pets which reduce loneliness.[107] Digital Kent, established with £2.5m funding in 2021 under the Helping Hands scheme, matches volunteer "digital champions" with people looking to learn new skills in the community.[108]

There are a few encouraging examples of designers starting to take account of elderly needs. The Japanese insurance company Sompo has opened the 'Sompo's Future Care Lab project' to develop technologies to support the elderly. So far this includes AI wheelchairs, convertible beds, and body sensors – all aiming to help elderly people live more independently.[109]

and-briefings/active-communities/policy-briefing---facts-and-figures-about-digital-inclusion-and-older-people.pdf.

[107] https://afgroup.org.uk/tech-lending-library/

[108] 'Digital Champion Network Volunteers' (Kent County Council), Kent, accessed 14 April 2024, https://www.kent.gov.uk/leisure-and-community/volunteering/digital-champion-network-volunteers.

[109] 'About Us | Future Care Lab in Japan Future Care Project Powered by the Sompo Holdings Group', Future Care Lab in Japan | Future Care Project Powered by the Sompo Holdings Group, accessed 14 April 2024, https://futurecarelab.com/en/about/.

Ways in which technology might improve outcomes for older people

Technology is not a panacea, nor is it without risk. Overreliance or misuse of technology could lead to dehumanising care, or create new forms of neglect. But it can also be a lifeline. We offer below a brief survey of what might be learned from some current developments:

1. **Combating social isolation**

Older people start to lose independence when they can no longer drive or do day-to-day tasks. At that point they are also more likely to experience social isolation – which in turn is associated with an increased risk of dementia, heart disease and stroke.[110]

Groups in many countries are trying to creatively address the life stage before formal care requirements. Some are using the kind of peer-to-peer technology more commonly used by younger generations. In Norway, researchers found that 88% of older adults were interested in meeting remotely to share meals. Komp, a tablet designed by the Norwegian 'No Isolation' campaign, was shown to address loneliness and also improve food intake (2023).[111] In New York, a pilot achieved a 95% reduction in loneliness when it offered 800 New Yorkers a digital companion (2023) called ElliQ, developed by Intuition Robotics, which demonstrated high levels of engagement.[112] [113]

There are warning signs, however, over some gig economy services. Papa, a US app, links customers ("papas") to companions ("pals") for home-based tasks. But while Papa claims to reduce member loneliness by 68%, there have been worrying

[110] *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System* (Washington, D.C.: National Academies Press, 2020), https://doi.org/10.17226/25663.
[111] Ida Synnøve Bårvåg Grini and Øydis Ueland, 'How Families' Use of Digital Technology Can Be a Tool for Reducing Loneliness and Improving Food Intake among Older Adults', *Journal of Ageing and Longevity* 3, no. 1 (March 2023): 46–58, https://doi.org/10.3390/jal3010004.
[112] 'NYSOFA's Rollout of AI Companion Robot ElliQ Shows 95% Reduction in Loneliness', Office for the Aging, accessed 22 March 2024, https://aging.ny.gov/news/nysofas-rollout-ai-companion-robot-elliq-shows-95-reduction-loneliness.
[113] 'ElliQ User Stories', ElliQ, accessed 22 March 2024, https://elliq.com/pages/testimonials.

allegations of harassment and assault by both helpers and clients; demonstrating the vulnerability of home-based services.[114]

2. **Reducing the risk of readmission to hospital**

A number of new platforms are now offering patients coaching post-discharge, to reduce anxiety and improve adherence to medication, focussed on those who are most at risk of hospital readmission.

One of these is the US value-based-care provider Oak Street Health, which claims to have achieved a 51% reduction in hospital admissions and 42% lower readmission rate (within 30 days) for a group of around 200,000 US patients that it has stratified by risk.[115] The average patient is 68 years old and takes seven medications; 86% of patients have one or more chronic conditions and 40% are low-income.[116] Another is Laguna Health, which in a 2023 trial claimed a readmission rate of 7.1% in the 30 days following a cardiovascular-related discharge, compared to 30% in the control group.[117]

In the UK, the potential now exists to learn from such examples and to extend the NHS app to support patients post-discharge.

3. **Maintaining independence and improving recovery**

Physiotherapy can help to alleviate pain and regain mobility after an acute episode, and prevent deconditioning during a hospital stay. Musculoskeletal (MSK) conditions

[114] Heather Landi, 'SoftBank Backs Papa's $150M Series D to Scale up "family-on-Demand" Services | Fierce Healthcare', 4 November 2021, https://www.fiercehealthcare.com/tech/softbank-backs-papa-s-150m-series-d-to-scale-up-family-demand-services.
[115] 'Diverge Health Launched to Build Upon a Decade of Experience Serving Underserved Patients in New York', accessed 6 April 2024, https://www.newswire.com/news/diverge-health-launched-to-build-upon-a-decade-of-experience-serving-21982633.
[116] 'Oak-St.-Health-Investor-Presentation.Pdf', accessed 22 March 2024, https://s2.q4cdn.com/447711729/files/doc_presentations/2023/02/Oak-St.-Health-Investor-Presentation.pdf.
[117] Iva Minga et al., 'Personalized Postacute Hospitalization Recovery: A Novel Intervention to Improve Patient Experience and Reduce Cost', *Journal of Healthcare Management* 68, no. 4 (July 2023): 284–97, https://doi.org/10.1097/JHM-D-22-00240.

account for 30% of GP consultations in England.[118] The community health service waiting list (January 2024) shows that over 300,000 adults are currently on a waitlist for MSK services.[119]

The pandemic inadvertently showed what might be done through technology, when COVID-19 disrupted physiotherapy appointments. Only patients in hospital, or urgent cases, were seen face-to-face during lockdown; patients who were referred to a physio by their GP or following a hospital discharge were recommended remote services. Most used the telephone (71%) to deliver remote services, but AttendAnywhere, Zoom, and Accurx were also used.[120]

Post-pandemic interviews with NHS physiotherapists have found some enthusiastic about being able to introduce changes they had been considering for a long time, *"we were able to do, in ten months, more than I've been able to do in ten years … I think it's been an absolutely unique opportunity to stop and pause and think 'Right, what now?'."*[121]

The use of technology in physiotherapy needs careful management. Studies have found that virtual physiotherapy can be as effective as in-person sessions for a variety of conditions, however for detailed physical assessments or more complex cases a mixture of virtual and in-person sessions is recommended.[122]

[118] 'NHS England » Musculoskeletal Health', accessed 22 March 2024, https://www.england.nhs.uk/elective-care-transformation/best-practice-solutions/musculoskeletal/.
[119] 'Statistics » Community Health Services Waiting Lists', accessed 22 March 2024, https://www.england.nhs.uk/statistics/statistical-work-areas/community-health-services-waiting-lists/.
[120] Helen Hawley-Hague et al., 'Exploring the Delivery of Remote Physiotherapy during the COVID-19 Pandemic: UK Wide Service Evaluation', *Physiotherapy Theory and Practice* 0, no. 0 (2023): 1–15, https://doi.org/10.1080/09593985.2023.2247069.
[121] Hawley-Hague et al.
[122] 'Effectiveness of Telerehabilitation in Physical Therapy: A Rapid Overview | Physical Therapy | Oxford Academic', accessed 6 April 2024, https://academic.oup.com/ptj/article/101/6/pzab053/6131423.

Physiotherapy is also known for poor adherence; some studies suggest that adherence with treatment regimen is as low as 30% and may be particularly poor for unsupervised home exercise programmes.[123]

Used judiciously, though, apps seem to add value. In the UK, St George's MSK physiotherapy team piloted 'getUBetter' an evidence-based app which lets patients set goals, log exercises, and monitor their recovery. This has led to a 20% reduction in physiotherapy referrals and 66% reduction in urgent care attendances. St George's physios are now piloting virtual reality headsets to rehabilitate major-trauma patients through playing games, which patients find engaging.

Platforms along similar lines are being funded in Belgium, by the National Institute for Health and Disability Insurance.[124] In Germany the Digital Healthcare Act (Digitale-Versorgungs-Gesetz, DVG) is channelling investment into digital tools.[125]

4. Predicting and preventing risks

The more advanced care providers are using data collected via home sensors, and apps, to predict and mitigate the risk of hospitalisation. The sector has graduated from simply using monitors to know, for example, when someone has got out of bed in a care home, to using AI to remotely predict whether someone is likely to fall.

This can have a significant impact on carer time. A pilot of acoustic monitoring technology in three care homes in 2019-20 saw a 55% reduction in night time falls and a 20% reduction in hospital admissions; reducing unnecessary night-time checks by

[123] Emmy M Sluijs, Gerjo J Kok, and Jouke van der Zee, 'Correlates of Exercise Compliance in Physical Therapy', *Physical Therapy* 73, no. 11 (1 November 1993): 771–82, https://doi.org/10.1093/ptj/73.11.771.
[124] 'Rehabilitation Using a Health App in the Primary Knee or Hip Replacement Is Now Available to All Eligible Patients in Belgium | Med Tech Reimbursement Consulting', 24 October 2022, https://mtrconsult.com/news/rehabilitation-using-health-app-primary-knee-or-hip-replacement-now-available-all-eligible.
[125] 'Four More Health Apps Obtained Reimbursement in Germany | Med Tech Reimbursement Consulting', 24 January 2024, https://mtrconsult.com/news/four-more-health-apps-obtained-reimbursement-germany.

75%, and freeing up staff time equivalent to £13,000 per staff member per year.[126] AI is also beginning to be used, in AI powered lamps which track changes in gait and behaviour, and to train prediction models. Cera Care says that its AI 'Predict and Prevent Hospitalisation' and 'Predict and Prevents Falls' products have resulted in a 70% reduction in hospitalisation rate and the ability to predict 83% of patient falls a week in advance. After launching the falls product, Cera reported a 25% decrease in the number of falls reported within two weeks.[127] One Step, a physiotherapy app, claims to prevent 25% - 45% of falls by identifying users at risk of falls and notifying carers or health care professionals for early intervention.[128]

However, there persists a fundamental misalignment of incentives for care providers to adopt these technologies. Care providers are not incentivised to reduce hospital admissions. And in some of our interviews, we heard that care homes with high occupancy also have no financial incentive not to send a resident to A&E.

Changing incentives would require ICBs to introduce a model akin to value-based-care (VBC) contracts, which would reward providers for a lower hospitalisation rate against a risk-adjusted rate for their patient group. VBC contracts have gained traction in the US as way of aligning incentives across fragmented providers and payers to deliver better health outcomes. In the UK, a commissioner could withhold a small percentage of payment per individual, with the money repaid, plus bonus, if hospital admissions rates were reduced. However, with providers operating on thin margins, this may not be realistic. ICBs will need to explore the potential to fund predictive technologies.

[126] 'Acoustic Monitoring Integrated with Electronic Care Planning', NHS Transformation Directorate, 7 October 2020, https://transform.england.nhs.uk/ai-lab/explore-all-resources/understand-ai/acoustic-monitoring-integrated-electronic-care-planning/.
[127] 'Our Technology & AI | Cera'.
[128] 'Fall Prevention', accessed 17 March 2024, https://www.onestep.co/cases/fall-prevention.

5. Hospital At Home: Virtual Wards

For frail patients with more intense medical needs, virtual wards are an attractive alternative to inpatient settings. There is less risk of infection, of deconditioning, of developing incontinence, and of becoming disoriented - which becomes a more common problem as people age.

The NHS, a global leader in virtual wards, has prioritised two virtual ward pathways: acute respiratory infection virtual wards and frailty virtual wards. The first, a response to COVID-19, has become synonymous with remote patient monitoring: specifically, the use of home pulse oximetry in COVID-19 patients. The latter combines both virtual and in-person care.

It is not yet clear how effective virtual wards are, or which groups of patients benefit the most. One study found that subsequent admission to residential care is probably reduced, but the issue of carer strain needs to be better understood and addressed.[129] A recent Health Foundation analysis of Situation Report data found that virtual wards across England have different patient populations, referral pathways, technology use and staffing models which make comparisons difficult.[130] A future government will need to be clear about the chief purpose of virtual wards, and how to measure outcomes.

[129] Gill Norman, Paula Bennett, and Emma R. L. C. Vardy, 'Virtual Wards: A Rapid Evidence Synthesis and Implications for the Care of Older People', *Age and Ageing* 52, no. 1 (8 January 2023): afac319, https://doi.org/10.1093/ageing/afac319.

[130] Paul Chappell et al., 'What Do Virtual Wards Look like in England?' (The Health Foundation, February 2024), https://www.health.org.uk/publications/what-do-virtual-wards-look-like-in-england.

3. The care workforce

Recommendation:

Create a new deal on care worker pay and progression linked to a nationally agreed list of delegated healthcare tasks

Empowered, capable staff are fundamental to the delivery of good care, and to the experience of users. For social care to be a rewarding career, staff need stable, consistent work, and secure contracts. For people to be supported, the health and care staff they interface with must have the capacity to build relationships, of trust and kindness. Unfortunately, some the trends are going in the opposite direction.

The COVID-19 pandemic presented a serious mental and physical health burden. The Trades Union Congress has described the effect on many care workers as "traumatic".[131] A YouGov survey of social workers, commissioned by Social Work England, reports a substantial drop in morale since the pandemic.[132] Meanwhile many clinical support workers in the NHS continue to feel "invisible", according to a new survey by the Business School at King's College London.[133]

The many staff who are involved in providing care - including care workers, social workers, and clinical support workers - should be at the heart of a care continuum, stretching from prevention through sheltered housing, post-operative recovery and rehabilitation, to end of life. Yet too often the roles are fragmented, with staff in different silos speaking what are effectively different languages. Care has been subdivided, into different activities parcelled out as cheaply as possible between different actors in the system.

[131] 'Trades Union Congress - Written Submission', 26 May 2022, https://committees.parliament.uk/writtenevidence/108794/html/.
[132] 'The Social Work Workforce' (YouGov, September 2023), https://www.socialworkengland.org.uk/media/cn0fhyt1/the-social-work-workforce.pdf.
[133] Richard Griffin and Ian Kessler, 'The Cavendish Review: Ten Years On', June 2024.

This has left many recipients of care with no continuity, seeing sometimes 80 different faces in a year, never building a trusted relationship. In interviews for this report we have heard about multiple visits being made by different staff to the same person in their home, often on the same day: one worker might do a diabetes check, another give a COVID jab, another make a meal.

Good care is optimistic for people, focussing on what they can do, not what they cannot, and maintaining independence. But a care worker who has to deliver a pre-assigned, paid-for task, in a 15 or 30-minute visit, cannot afford to worry about preventative health, or even sometimes to act on deterioration in a person's condition. So many care workers are now so embedded in a culture of "doing to" and "no chit chat", all on the clock, that they are having to re-learn how to be friendly, how to help someone do things for themself.

An extensive literature about moral distress and moral injury (Jameton, Griffin, Reamer), suggests that giving staff too little time to care is usually a false economy. Some of the best staff in both health and care are the most distressed by being unable to give the proper care they feel is needed. Some put up defences, which include doing tasks to separate themselves from the patient. Others resign. Meanwhile patient groups complain that some staff treat care as a list of tasks to be rushed through, with little regard to the individual.

Technology can help free up staff time (chapter 2), commissioning for outcomes can empower staff and provide more autonomy (chapter 4); if underpinned by a robust funding settlement (chapter 6). There is also a need to change pay, terms and conditions, improve the read-across between health and care staff, and stabilise the domiciliary care market. The immediate challenges are to reduce attrition in social care, raise the status of that workforce, and make caring feel like a career.

A varied and fast-moving workforce: hard to measure

There is no commonly agreed way to define or measure the scope and size of the social care workforce. Skills for Care publishes estimates for England based on surveys of

social care providers. For the UK it is possible to use the Labour Force Survey and/or the ONS 'Workforce Jobs' dataset, by using certain industry and occupation codes. Scotland's 2017 National Workforce Strategy for Health and Care estimates role numbers, as does Wales's "Economic Value of the ASC Workforce" report in 2018.[134] Northern Ireland's latest census estimates of the health and care workforce were made in 2023.[135]

The latest Skills for Care data suggests there were 1.79 million social care posts, 1.635 million of them filled, in England in 2022/23.[136] But the high rate of churn in the workforce (28.3% according to Skills for Care) makes accurate estimates difficult, exacerbated by the rapid movement of workers between different employers, which may themselves change hands.

Another challenge is that people working wholly or partly in social care include staff paid by the NHS, such as district nurses; social workers and care staff employed by local authorities and independent providers; and staff hired by self-funding individuals, such as personal assistants. It will not be possible to make accurate workforce estimates until the market is stable. Unfortunately, it is becoming less so.

The state of the market: insecure and unstable

The market is becoming less stable. Between 2012 and 2023, the total number of care home beds for older people declined from 11.3 per 100 people to 9.3 per 100 people: a

[134] 'National Workforce Strategy for Health and Social Care in Scotland' (Scottish Government, March 2022), https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2022/03/national-workforce-strategy-health-social-care/documents/national-workforce-strategy-health-social-care-scotland/national-workforce-strategy-health-social-care-scotland/govscot%3Adocument/national-workforce-strategy-health-social-care-scotland.pdf; 'The Economic Value of the Adult Social Care Sector - Wales' (ICF Consulting Limited, 5 June 2018), https://socialcare.wales/cms-assets/documents/The-Economic-Value-of-the-Adult-Social-Care-Sector_Wales.pdf.
[135] 'NI Health and Social Care Workforce Census – March 2023', Health, 23 August 2023, https://www.health-ni.gov.uk/news/ni-health-and-social-care-workforce-census-march-2023.
[136] 'The State of the Adult Social Care Sector and Workforce in England', October 2023, https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx.

17.7% decrease.[137] In the same period, the number of nursing home beds per 100 people aged 75 and over fell from 5.2 to 4.5: a 13.5% decrease. Lack of reliable data on the number of people receiving care in their own homes makes it impossible to judge how much of this change is due to increases in supported living accommodation. But certainly, fewer new care homes are being registered, and there is an upward trend in closures, which will reduce choice.

There is also growing fragmentation and churn in the domiciliary care market, with many new providers being licensed to join a market which already contains tens of thousands, spreading contracts even more thinly and resulting in gaps in rotas for many staff who are getting fewer hours than they would like.

CQC registration data shows substantial increases in the number of approved domiciliary care agencies. The May 2023 CQC data shows there are now 12,984 'homecare agencies' in England, meaning the sector has expanded by 53.4 per cent nationally since May 2018, when there were 8,466 registered homecare agencies.[138]

The fragmentation of the domiciliary care market is now a major barrier to achieving sustainable reform. There is anecdotal evidence that some LAs are lowering their fee rates to capitalise on oversupply, leading to "call-clipping" by some providers, which deliver fewer minutes of care than they bid for. If so, this is a race to the bottom which undermines ethical providers. It seems very unlikely that LAs or CQC can adequately monitor quality of provision when there is such churn and expansion in the market.

The situation will rebound on care workers if they are unable to work as many hours as they would like. A UK Homecare Association survey of its members in July and August 2023 found that eight in ten respondents commissioned by local authorities had experienced a reduction in hours. Nearly half (48%) said they had seen a 25% or above

[137] 'Care Home Bed Availability', Nuffield Trust, 25 April 2024, https://www.nuffieldtrust.org.uk/resource/care-home-bed-availability.
[138] 'Using CQC Data - Care Quality Commission', accessed 21 May 2024, https://www.cqc.org.uk/about-us/transparency/using-cqc-data#directory.

reduction in the number of hours available to them from their local authority. This will impact the financial sustainability of services, since the cost per hour of homecare delivery is highly sensitive to the volume of hours delivered.

This trend may have been exacerbated by the rush to increase international recruitment. In January 2022, concerns about labour shortages led the Home Office to add care workers to its shortage occupation list, on the advice of the Migration Advisory Committee.[139] Between March 2022 and March 2023, an estimated 70,000 people (including 58,000 on skilled worker out-of-country visas) started care roles in the independent sector having arrived in the UK, a substantial increase in international recruitment in previous years.[140]

Providers who sponsor workers from abroad are required to offer them full-time contracts, with a minimum annual salary of £20,960. But there are signs that these conditions have been breached in some places, with providers offering too few hours, causing substantial hardship. Unseen UK, a charity which supports survivors of trafficking and modern slavery, reported a steep rise in calls to their helpline from overseas workers who came to the UK on care visas.[141] The trade union UNISON has documented evidence of some workers having had money deducted from their wages to cover dubious fees, being charged extortionate rents for substandard accommodation, and being ordered to repay thousands of pounds if they try to move jobs. Cases reported to UNISON include a care worker who paid a recruitment agent in India £12,000 to 'introduce' her to a UK employer.[142]

These abuses undermine the reputation of social care, and jeopardise vulnerable people. The recruitment of overseas care staff should only take place via the ethical

[139] David Foster, 'Adult Social Care Workforce in England' (House of Commons Library, 22 January 2024), https://researchbriefings.files.parliament.uk/documents/CBP-9615/CBP-9615.pdf.
[140] 'The State of the Adult Social Care Sector and Workforce in England'.
[141] 'Who Cares? Modern Slavery in the Care Sector' (Unseen, 2023), https://www.unseenuk.org/wp-content/uploads/2023/11/unseen-Care-Sector-report-2023.pdf.
[142] 'Expendable Labour: The Exploitation of Migrant Care Workers' (UNISON, n.d.), https://www.unison.org.uk/content/uploads/2023/11/Expendable-labour-report.pdf.

recruiters list run by the NHS. Such abuses ultimately reflect the chaotic levels of attrition, inadequate pay and conditions in the social care market, which need to be fixed.

Pay, terms and conditions

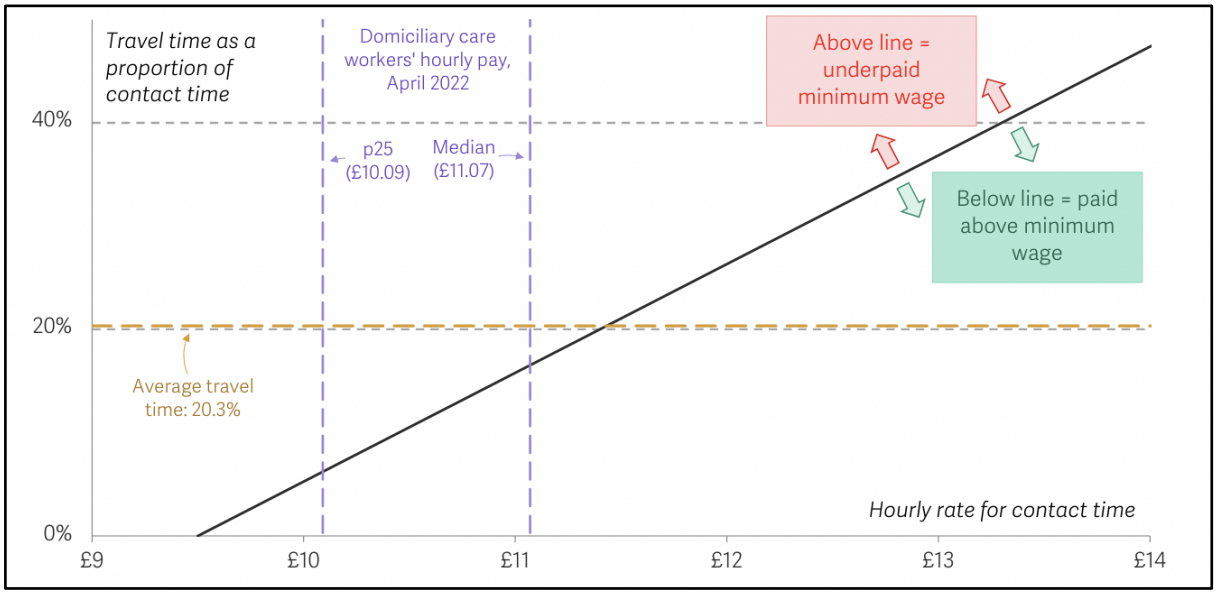
In social care, there is consistent evidence that services with lower vacancies and lower attrition rates, and those with more staff and better pay have higher CQC ratings.[143] Attracting and retaining a skilled workforce is a central challenge.

Care work has historically enjoyed a measure of job security, because demand outstrips supply. But terms and conditions are often very insecure. Focus groups held by the Resolution Foundation in 2023 found many care workers still not being paid for travel time between visits.[144]

While this is not illegal in itself, the law requires that gross pay divided by total hours worked, including travel time, is equal to or above minimum wage. Both the Resolution Foundation and Unison believe that many care workers are earnings below the minimum, "typical rates of pay and travel time suggest domiciliary workers face a high risk of being paid less than the minimum wage once travel time is taken into account".[145]

[143] SkillsforCare, 'This Year's "The State of the Adult Social Care Sector and Workforce in England" Report Has Been Published', 13 October 2021, https://www.skillsforcare.org.uk/news-and-events/news/this-years-the-state-of-the-adult-social-care-sector-and-workforce-in-england-report-has-been-published.
[144] Nye Cominetti, 'Who Cares? The Experience of Social Care Workers, and the Enforcement of Employment Rights in the Sector' (Resolution Foundation, 26 January 2023), https://www.resolutionfoundation.org/publications/who-cares/.
[145] Cominetti.

Figure 4: Some care workers are still not being paid the minimum wage, once travel time is taken into account. Relationship between travel time (as a proportion of contact time), rate of pay for contact time, and whether worker is paid above or below the current adult minimum wage of £9.50: UK



Notes: Assumes adult minimum wage of £9.50, workers not paid for travel time, and pay estimate from ASHE relates to contact time only. Source: Nye Cominetti, Resolution Foundation, 'The Experience of Social Care Workers, and the Enforcement of Employment Rights in the Sector'; RF analysis of ONS, Annual Survey of Hours and Earnings, Home Care Association.

The practice of failing to pay for travel time means that official estimated rates of median weekly earnings for the care sector in national datasets are likely to be overestimates.[146]

Increasing pay

On its own, raising the minimum wage is only a partial solution. Since 2010, the hourly pay 'premium' which care work used to command over other low-paid jobs has been eroded: from about 5% above other low-paid jobs to only 1% in 2021, according to the Migration Advisory Committee. This is partly because raises in the minimum wage since

[146] Office of National Statistics, 'Employee Earnings in the UK - Office for National Statistics', 1 November 2023, https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/2023.

2010 have applied to other low-paid jobs.[147] The irregular nature of care work also means that raising the minimum hourly wage does not necessarily translate into the same premium for a care worker as for someone in a more regular role.

Some commissioners and providers have taken voluntary action. Fifty-one local authorities have signed Unison's 'Ethical Care' charter, whereby they commit to pay the real Living Wage, and to pay domiciliary care workers for their travel time. But this alone will not level the playing field. The Migration Advisory Committee has proposed that the Government should raise minimum pay in the social care sector "at least" £1 above the National Living Wage, to resolve staffing shortages.[148] The Resolution Foundation has gone further, proposing setting minimum pay in the sector at £2 above the national adult minimum.

There is another problem, however. Raising the minimum hourly wage does nothing to help retain the most skilled, experienced and long-serving staff. The introduction of the National Living Wage in 2015 actually reduced the pay gradient. The pay difference between care workers with less than one year of experience and those with more than 20 years of experience fell to a mere £0.15 an hour.[149]

The challenge of recognising experience applies to both health and care. The NHS Agenda for Change pay scales are relatively inflexible, with limited regional variation, and fail to recognise long years of experience, especially among middle-ranking nurses who are the backbone of the system but cannot move beyond the top of their Agenda for Change pay band. Good staff should not have to seek promotions, which often involve spending less time away from the frontline, in order to be paid more.

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[147] 'Migration Advisory Committee (MAC) Annual Report, 2023 (Accessible) - GOV.UK', accessed 13 May 2024, https://www.gov.uk/government/publications/migration-advisory-committee-annual-report-2023/migration-advisory-committee-mac-annual-report-2023-accessible.
[148] Migration Advisory Committee, 'Migration Advisory Committee: Annual Report, 2022', GOV.UK, 31 January 2023, https://www.gov.uk/government/publications/migration-advisory-committee-annual-report-2022.
[149] The King's Fund, 'Average pay for care workers: is it a supermarket sweep?', 2019

Any new pay settlement will risk provider solvency unless it is done within the context of a higher overall funding settlement for the sector.

Empowering care staff through delegated healthcare interventions

One way to sustainably improve pay, terms and conditions would be to allow experienced care workers to be properly paid for higher level tasks which save the NHS money. Nursing tasks which are increasingly being taken on by care staff include the following:

- insulin injections;
- wound care;
- podiatry;
- taking blood pressure and blood sugar and reporting these back to GPs;
- testing people for COVID-19;
- catheter care;
- (occasionally) tracheostomy management.

Experienced care workers proved that they could do many of these things during the Covid-19 pandemic. But there remains some confusion among local authorities and care providers about what different staff are allowed to do, and about issues of insurance and liability.

A delegated healthcare intervention is defined as an activity, usually of a clinical nature, where registered healthcare professionals delegate to a competent care worker who has been given appropriate training, monitoring and support. The DHSC Skills for Care and National Care Forum have published guiding principles for delegated healthcare interventions.[150] But there are different protocols and processes in different parts of the country. Some providers have told us they cannot access training funds. One local authority suggests that it was not sufficiently clear what tasks

[150] Deborah Sturdy and Oonagh Smyth, 'Developing a New Framework for Delegated Healthcare Interventions – Social Care', 20 July 2022, https://socialcare.blog.gov.uk/2022/07/20/developing-a-new-framework-for-delegated-healthcare-interventions/.

require a TDDI enhanced registration. This persistent lack of clarity, especially around legal liability, is a brake on empowering the workforce and providing more consistent care.

There is a need to create a clear national framework for delegated healthcare tasks which can be done by care workers, paid at NHS rates by the NHS, with a national competency framework aligned to that framework and providers reimbursed for insurance costs.

Bringing greater parity between health and care

There is strong similarity between many of the tasks performed by Agenda for Change band 2 and 3 unregistered staff in the NHS, and some social care workers (Cavendish Review 2020).[151] The authorised tasks are almost identical for a junior care worker versus a Band 2 healthcare assistant, but in reality the care worker will need the maturity to function with less supervision. Similar roles ought to attract similar levels of pay – even if NHS staff receive better benefits. Funding ought to reflect the value of care work to the NHS bottom line. Public sector teams seem to have made more progress in this regard, with shared operating procedures for some community health reablement services for example, than when independent care providers are commissioned.

An alignment of roles would require a commensurate alignment of common competencies and training. A typical senior care worker's qualification can include a Level 3 Diploma in Health and Social Care, a Level 4 Diploma in Health and Social Care Management or an Advanced (Level 3) apprenticeship. A Band 3 HCA might have a Level 3 Diploma in Healthcare Support, or an Advanced (Level 3) apprenticeship. Denmark offers a possible model for how to do this.[152]

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[151] Camilla Cavendish, 'Social Care: Independent Report by Baroness Cavendish' (Department of Health and Social Care, February 2022), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1059888/social-care-reform-Baroness-Cavendish-report.pdf.

[152] Cavendish.

This is all the more important because of the decline of registered nurses in adult social care.[153] There are also few Nursing Associates in social care, especially compared to the NHS[154]. More flexibility for employers over how to spend Apprenticeship Levy funds could help the NHS and care systems compete with other parts of the economy.

Greater efforts must be made to recognise and reward experience in both NHS and ASC roles, with pay reviews focussed on length of service, not simply raising pay at the bottom.

Training in roles which underpin care

Sufficient training, time off for study and professional development are lacking for many of the social care and clinical support roles which provide so much face-to-face care.

In the NHS, a 2024 survey of more than 5,000 clinical support workers by King's College London, "*The Cavendish Review: Ten Years On*" found that most are enthusiastic about their work - but believe that they could contribute more if they had greater access to occupationally relevant education.[155] 1 in 10 said they had not been able to access any formal training in their whole career with the NHS. The report found some progress since the recommendations of the 2013 independent Cavendish Review of junior health and care support staff. But the authors state that many of the interventions supported by that review, and by this new staff survey, are not addressed by the NHS Long Term Workforce Plan published by NHS England last year. This is a missed opportunity.

In social care, training is as complex and varied as the number of roles, heavily dependent on the type of people being looked after. Regulators expect all care staff to have a basic set of core skills. But beyond that, a significant proportion of the adult social care workforce do not hold a relevant qualification or have access to good

[153] Skills for Care, 'The state of the adult social care sector and workforce in England', 2021
[154] The Health Foundation, 'Health and social care workforce: priorities for the next government', 2019
[155] *The Cavendish Review: ten years on, by Professor Richard Griffin and Professor Ian Kessler from King's Business School and Dr Abi Hall of the University of Exeter*

quality training.[156] This is despite the evidence that learning and development opportunities can improve retention. If the 21st century social care workforce is to professionalise, there 4 broad areas of relevant training:

1. Supporting activities of daily living (mandatory).
2. Clinical support and delegated healthcare interventions (where appropriate)
3. Digital skills, including information governance, to maximise use of technology and data sharing
4. Building relationships, and improving user confidence in staying independent.

For the first of these, many registered providers choose to use the Care Certificate; issues relating to the second are covered earlier in this section.[157] Digital skills are covered in chapter 2. Our interviews suggest that the fourth, building relationships, is a critical skill for some workers who have been told to clock on and off and not to "chat" with the person they care for.

Pioneering commissioners emphasise that a cultural shift is needed. Leicester City Council is retraining staff to move away from processes and be accountable for the outcome of each individual. "[*Some staff*] *have found it culturally a real threat to their position in the system and their way of thinking."* - Leicester's Strategic Director for Social Care and Education.[158]

Wigan has taken a similar approach: *"We used an anthropologist to help retrain all social care workers to listen deeply rather than just assume we knew what was best for people and tick a box."* - Professor Donna Hall CBE[159]

[156] DHSC, 'Next Steps to Put People at the Heart of Care'.
[157] https://www.skillsforcare.org.uk/news-and-events/Spotlight-on/RetainToGain.aspx
[158] Adult Social Care Committee, 'Adult Social Care Committee: Corrected Oral Evidence: Adult Social Care' (UK Parliament, 18 July 2022), https://committees.parliament.uk/oralevidence/10648/html/.
[159] House of Lords Adult Social Care Committee, 'Select Committee on Adult Social Care Corrected Oral Evidence: Adult Social Care' (House of Lords, 23 May 2022), https://committees.parliament.uk/oralevidence/10280/pdf/.

Ultimately, making these improvements requires a more stable care market and a sustainable long-term funding settlement for adult social care.

4. Driving up the quality of care: commissioning and regulation

Recommendation:

Stabilise care markets, moving away from procuring by the minute towards commissioning for outcomes, with fair fees paid to providers as part of a secure funding settlement

Good quality care is defined by the Think Local, Act Personal partnership as follows: "help that you need, such as personal care or practical assistance, to live your life as comfortably and independently as possible, because of age, illness or disability."[160]

This ambition - of high quality, personalised care - is supported in the 2014 Care Act. This legislation set out an ambition for person-centred care, designed with users, in a market where consumers could exercise choice, not simply have to accept the only service offered. Since then, policy has continued to emphasize independence. The Adult Social Care Outcomes Framework 2023-24, designed by DHSC with the Association of Directors of Adult Social Services, the Local Government Association, CQC and NHSE lists 6 objectives for users of services, unpaid carers and care professionals. These are:

1. **Quality of life:** people's quality of life is maximised by the support and services which they access, given their needs and aspirations, while ensuring that public resources are allocated efficiently.
2. **Independence:** people are enabled by adult social care to maintain their independence and, where appropriate, regain it.
3. **Empowerment - information and advice:** individuals, their families and unpaid carers are empowered by access to good quality information and advice to have choice and control over the care they access.
4. **Safety:** people have access to care and support that is safe, and which is appropriate to their needs.

[160] https://www.thinklocalactpersonal.org.uk/

5. **Social connections:** people are enabled by adult social care to maintain and, where appropriate, regain their connections to their own home, family and community.
6. **Continuity and quality of care:** people receive quality care, underpinned by a sustainable and high-quality care market and an adequate supply of appropriately qualified and trained staff.

These objectives are being met too rarely. Users have very little power in this market (see chapter 5). Many care packages are procured through 'time and task' commissioning, under which local authorities bid to provide specific tasks completed in blocks of time. Providers, in turn, are incentivised to show that they have carried out those tasks, not to be responsive to needs. The focus is overwhelmingly on processes and targets, rather than improving the outcomes which matter to citizens.

There is strong evidence that outcomes-based commissioning, using a population health approach, can improve care quality.[161] Yet despite the evidence in favour of transitioning from standard procurement to outcomes-based commissioning, change has proved difficult.

How outcomes-based commissioning can work: examples of best practice

Outcomes-based commissioning has been trialled and implemented internationally and in the UK. We present four short examples of where a more person-centred, outcomes-based approach is improving quality:

Leeds Council's Community and Health Well-being Model 2024

Leeds Council has devised a new Standard Operating Procedure with unions, care providers and the community health trust. It is building closer relationships with a small

[161] Health Services Management Centre and Institute of Local Government Studies, 'Commissioning for Better Outcomes: A Route Map', 2015, https://www.adass.org.uk/media/4576/commissioning-for-better-outcomes-a-route-map-301014.pdf; LGA, 'Integrated Commissioning for Better Outcomes: A Commissioning Framework | Local Government Association', 11 April 2018, https://www.local.gov.uk/icbo.

number of high-quality providers and letting them use their discretion to adjust care packages up or down within agreed parameters. Leeds is now paying care workers the Real Living Wage and for the pilot will be paying for whole day shifts, with spare time to check on a client, or take someone out, trusting staff to use their professional judgement not watch the clock. In the phase one pilot they saw staff turnover fall from 36% to 18% as a result. Their aim is to recruit hyper-local staff who can connect users to local communities, friends and family.

"We asked what makes a good life for you? People say seeing family and friends, community, hobbies, not just being supported to exist. Our ambition in Leeds is that each person should have three good friends: this network is their emergency service."
- Cath Roff MBE, Programme Director, Adult Social Care Transformation, Leeds Council

In the short term the project is costing more, in higher hourly wages and funding for a trusted assessor. But the Council hopes to break even in medium term as users become more independent and care hours are used more efficiently.

Buurtzorg, the Netherlands

Founded in 2007, the home nursing service Buurtzorg has the highest rates of user satisfaction in the Netherlands, while costing 30-40% less than competitors. A non-profit, Buurtzoorg was created by Dutch nurse, Jos de Blok, who had become disillusioned with the Dutch health service:

> *"Healthcare and community care were defined as production…nursing, nursing care extra, guidance extra, for commissioners that's the way they buy care, so many hours of this and so many hours of that."*[162]

[162] Camilla Cavendish, *Extra Time: Ten Lessons for an Ageing World* (Harper Collins, 2019), 173–78.

de Blok's answer was to give district nurses far greater control over patient care and allow them to operate in small self-managing teams.[163] providing coordinated care for specific catchment areas. The teams provide intensive support at the start of the relationship with a new patient, gradually withdrawing as self-management aids and equipment are sourced, and networks of friends, family and neighbours are created or strengthened.

Through this approach, Buurtzoorg has been able to keep its overhead costs lower than alternatives, and to reduce the hours of care needed, while ensuring that users have a high level of consistency in who they see, leading to strong trusting relationships.

Buurtzorg operates in a competitive marketplace in the Netherlands, where patients choose their provider. A 2023 report found that the firm had around 17% market share in the Netherlands, seeing over 80,000 patients in their own homes, and employing around 10,000 nurses and nurse assistants.[164]

[163] Nursing assistants are the Dutch equivalent of Health Care Assistants or social care workers.
[164] Tjaša Zajc, 'The Netherlands Ep. 2: Buurtzorg: Redefining Nursing With Self-Managing Teams — Faces of Digital Health', *Faces of Digital Health* (blog), 11 March 2023, https://www.facesofdigitalhealth.com/blog/the-netherlands-buurtzorg-redefining-nursing.

The UK Royal College of Nursing (RCN) has been supportive of the model, and has noted that while Buurtzorg is nursing-led, not all the staff have nursing qualifications and that in the UK, many of the interventions could be provided by healthcare support workers.[165]

Gwynedd Council, Northwest Wales

In Wales, Gwynedd Council is working with the Betsi Cadwaladr University Health Board to move away from "time and task" commissioning to more personalized and collaborative support.

> *"The social workers and district nurses were trying to get to know people, but when somebody needed home care, they were hitting this massive barrier. We'd built in an awful lot of bureaucracy and mistrust. We decided we would work with the providers as a true partner... our stakeholders forum has met once a month for 3 years now"* Meilys Heuffryn, Gwynedd Council[166]

After piloting these changes, the Health Board found that large reductions in the number of hours commissioned were possible. Some care packages, including those for complex and vulnerable cases, were reduced by as much as 50%.
Savings from reduced hours enabled the Council to increase care worker hourly pay, and offer a regular 8-hour shift made up of 6 hours direct contact, 1 hour travel, and 1 hour added value time. Staff choose what would be of most use to spend this hour doing - for example checking back on someone they were concerned about.

[165] Royal College of Nursing, 'The Buurtzorg Nederland (Home Care Provider) Model: Obersvations for the United Kingdom', The Royal College of Nursing (The Royal College of Nursing, 25 April 2016), 5, https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/br-0215; Camilla Cavendish, 'Social Care: Independent Report by Baroness Cavendish' (Department of Health and Social Care, February 2022), 13, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1059888/social-care-reform-Baroness-Cavendish-report.pdf.

[166] https://assets.publishing.service.gov.uk/media/6228f5f3e90e0747a30ca996/social-care-reform-Baroness-Cavendish-report.pdf

The reforms removed duplication and reduced reporting requirements for providers, instead relying on patient outcome data.[167]

The Wigan Deal

The idea of building a different kind of relationship with people has been pioneered in Wigan at scale and with remarkable consistency across a number of public services. A review by the King's Fund suggests that the Council was able to achieve cost savings of £140 million between 2011 and 2019, while also producing improvements in a range of outcomes including quality of care (as demonstrated by CQC evaluations) and the proportion of older people still at home 91 days after hospital discharge.[168]

Wigan has increased local healthy life expectancy faster than elsewhere. Healthy life expectancy for women in Wigan rose by 31 months from 2009/2011 to 2015/2017, while England's average life expectancy for women fell by 2 months.[169]

The Deal for Adult Social Care and Wellbeing recognised that service provision was not giving users the care they needed:[170]

> ***"****We realised we were spending money on lots of things that were not very good and people did not actually enjoy them, but we thought they were the right thing for people because we had not listened; we had not asked people, "What do you enjoy doing on a day-to day-basis?" We were putting people into day centres and shipping them around on a council minibus.*"

[167] LGA, 'Developing Effective Relationships to Support Commissioning', 22 November 2021, https://www.local.gov.uk/sites/default/files/documents/Developing%20Effective%20Relationships%20for%20Commissioning%20-%20221121.pdf.
[168] Chris Naylor and Dan Wellings, 'A Citizen-Led Approach to Health and Care: Lessons from the Wigan Deal' (The King's Fund, June 2019), 5 & 62, https://assets.kingsfund.org.uk/f/256914/x/7f008d393b/wigan_deal_2019.pdf.
[169] Chris Naylor and Dan Wellings, 'A Citizen-Led Approach to Health and Care: Lessons from the Wigan Deal' (The King's Fund, June 2019), 66, https://assets.kingsfund.org.uk/f/256914/x/7f008d393b/wigan_deal_2019.pdf.
[170] Wigan Council, 'The Deal for Adult Social Care and Wellbeing', accessed 29 May 2024, https://www.wigan.gov.uk/Council/The-Deal/Our-Deals/index.aspx.

- Professor Donna Hall CBE, CEO, Wigan Council.[171]

There were two key aspects to the culture change. The Council leadership made a conscious effort to shift from a 'blame culture' to encouraging frontline staff were encouraged to take decisions and rethink how they worked.[172] And **to** better empower service users, Wigan Council trained care workers to have more open and exploratory conversations with patients, families and friends - and to think about what existing assets in social networks and communities could be used to improve care.[173]

Spreading the models

All of the examples above have involved strong leadership, combined with a willingness to experiment and to build deep, trusted partnerships. Organisations like the LGA and Social Care Institute for Excellence are working to support more UK councils which want to change. But with tight finances, and bankruptcy looming in some cases, many local authorities lack the bandwidth to address a change of approach. There is a cultural resistance to giving up control, and changing long-established compliance mechanisms.

> *"We're still very much in the mind-set that we're the parent: we know all the services, we know what are the best ones, and we are the judges of quality. Something I hear regularly is, 'What quality framework does that third sector organisation follow?' Well, frankly, probably none. But does that mean that all of their service is no good? The risk aversion, the fear of being seen to recommend or support a service that isn't quality-assured, that limits the ability of the market*

[171] 'Corrected Oral Evidence: Adult Social Care' (House of Lords, 23 May 2022), https://committees.parliament.uk/oralevidence/10280/html/.
[172] Chris Naylor and Dan Wellings, 'A Citizen-Led Approach to Health and Care: Lessons from the Wigan Deal. Summary.', Ideas That Change Health Care (The King's Fund, June 2019), 3, https://assets.kingsfund.org.uk/f/256914/x/2c0b2203d6/wigan_deal_summary_2019.pdf.
[173] Naylor and Wellings, 'A Citizen-Led Approach to Health and Care: Lessons from the Wigan Deal', 66.

to shape around social care and health, because we are too scared of what will happen if someone has a bad experience and we are somehow found to be accountable."

- Local authority interviewee in "Shifting Shapes" study, University of Birmingham[174]

Progress is slow, partly because of resistance from within local authorities' legal and procurement teams to co-designing approaches with other stakeholders.
This does not just apply to commissioners: providers can also be afraid of breaching the rules, due to the previous focus on contractual terms and conditions.

There is a widespread fear in both central and local government that asking users what they want, co-designing services with them, will increase costs. This is not necessarily correct, and is not borne out by anecdotal evidence from carers and councils we spoke to - one council told us that since giving more autonomy through direct payments, it has an underspend. In Gwynedd:

"We found that people would say things they thought they should say, they were conditioned to talk in services like a wheelchair, or day care, or home care. But when we started to sit down and really listen to them, we found there was a lot of commonality: most people wanted to feel connectedness in life, have a purpose and not be a burden. The system was spending a lot of money on things other than what people really valued."[175]

Evidence from researchers at the University of Birmingham suggests that some LAs are using a mixture of commissioning approaches. Birmingham's market shaping typology,

[174] Catherine Needham et al., 'Shifting Shapes: How Can Local Care Markets Support Personalised Outcomes?' (University of Birmingham: Health Services Management Centre, October 2020), 24, https://pure-oai.bham.ac.uk/ws/portalfiles/portal/106824127/Shifting_Shapes_final_report_Oct_2020.pdf.
[175] Cavendish, 'Social Care: Independent Report by Baroness Cavendish', 15.

based on fieldwork and a local authority survey and tested in eight sites, contrasts different types of commissioning according to two key variables: rule-setting and relationship-building. This reflects the tension between the legal, financial and cultural desire to control the market, and the need to build closer associations with providers, including charities.

The Birmingham researchers distinguish between "open market" commissioning models, in which commissioners seek to maximise the diversity of providers and help service-users to find the best fit; and "partnership" models where contracts are given to a small number of providers which collaborate closely on outcomes. To fulfil the objectives of the Care Act, the researchers argue that both models should be encouraged: to provide choice to service-users (open market) and to transform measured outcomes (partnership).

Table 1: Comparison of open market and partnership approaches from Shifting Shapes Report[176]

	Open market	Partnership
Rules	Low contract specification by LAs	
Relationships	Distant relationships between a large number of providers and local authority.	Close relationships between a small number of providers and local authority.
Outcomes	Outcomes are decided by individuals using services, and signed off by social worker/care manager.	Measurable outcomes are set by commissioners and providers. Providers may then work with users to identify their individual outcomes.
Local authority role	Key role of local authority is in providing information and advice, stimulating the market and possibly providing some quality assurance.	Key role of local authority is co-designing services with providers and communities, creating opportunities for learning.
Risk	Higher risk for providers.	Lower risk for providers.
Self-funders	Indirectly helps self-funders who already operate in this space.	May enhance self-funder access to a broader range of services, eg, prevention, housing.
Personalisation	Promotes personalisation, choice and control, building on existing direct payment support.	May reduce individual choice of provider but can create opportunities for services to be better oriented to individual outcomes.
Diversity	Can stimulate provision of small, culturally appropriate providers for communities.	Large providers may be able to employ a diverse staff base to support culturally diverse needs.
Target group	Suitable for people who can commission their own services (with support).	Suitable for building-based services and other high-investment projects; recovery-oriented services; prevention.

[176] Catherine Needham et al., 'Shifting Shapes: How Can Local Care Markets Support Personalised Outcomes?' (University of Birmingham: Health Services Management Centre, October 2020), 33, https://pure-oai.bham.ac.uk/ws/portalfiles/portal/106824127/Shifting_Shapes_final_report_Oct_2020.pdf.

Trusted partnerships require more open-book accounting, pooling of data and a willingness to share the risks of innovation. But they also remove many of the friction costs associated with mistrust between public sector commissioners and providers which are usually independent. In the standard model, even small adjustments to care packages cannot be made without referrals up the line to social workers and contracts departments. A change of model offers an ability to improve care at the frontline, while reducing cost within the bureaucracy. So would greater stability of personnel on both the commissioner and provider sides.

Ultimately, spreading the models beyond the pioneers will require a secure long term funding settlement for social care. It will also mean upfront investment in culture change, and staff training, to recoup savings later on; digital platforms which track real time qualitative measures of service delivery against individually defined outcomes, allowing for immediate changes to be made to care packages; and hand-holding to make the culture change, perhaps through a small consultancy budget, support via SCIE or by twinning councils with each other.

Regulation, inspection, and improvement

The social care sector needs greater accountability for outcomes. Yet while the CQC inspects individual care homes and domiciliary care agencies, and Ofsted inspects local authority children's services, there has been no central oversight of ASC commissioning since the Audit Commission was abolished.

In its December 2021 "People at the heart of care" ASC White Paper, the Government committed to introducing heightened scrutiny of local authority performance.[177] The Health and Care Act 2022 created a new duty for the Care Quality Commission to independently review and assess local authorities' performance in delivering their

[177] Department of Health and Social Care, 'People at the Heart of Care: Adult Social Care Reform White Paper' (Department of Health and Social Care, 18 March 2022), https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper/people-at-the-heart-of-care-adult-social-care-reform.

adult social care responsibilities.[178] Patient and user experience will be emphasised. This was an encouraging move towards listening to users. In 2022, the Think Local, Act Personal organisation told the House of Lords Select Committee on Adult Social Care that:

> "*Making it Real opens up the conversations. It gives people the opportunity to say what they do not know and confidence that they can do something this complex and multi-layered only by working together in co-production… there is an opportunity to make sure that those same principles run through the assurance of local authorities' regulated care and support providers, integrated care systems …and primary care general practice.*"[179]

It is too early to tell whether the CQC will be able to adequately review its new duty. In 2023, CQC reviewed data and publicly available evidence from all 153 local authorities in terms of care provision, integration and continuity and assessing needs.[8] One of the challenges it reported was[10] a lack of standard datasets from which to draw comparisons. Standard datasets are urgently needed, since the regulator's power to drive up system quality lies partly in being able to compare outcomes for similar individuals in different places: what the quality of care looks like for a 75-year old with COPD in Bury, for example, versus one in Bath.

The CQC is also changing the way it assesses providers. It is replacing three different assessment frameworks (one for hospitals, one for adult social care and one for primary medical services) with a new single assessment framework with one overall set of expectations.[180] The hope is that this will make it easier to establish one clear understanding of what defines 'quality' care and 'good' service. However, there are concerns about how the new framework will work. CQC is simultaneously moving away

[178] UK Parliament, 'Health and Care Act 2022' (2022), sec. 163, https://www.legislation.gov.uk/ukpga/2022/31/introduction/enacted.
[179] 'Corrected Oral Evidence: Adult Social Care'.
[180] CQC, 'Our New Single Assessment Framework', Latest News, 18 July 2022, https://www.cqc.org.uk/news/our-new-single-assessment-framework.

from in-person inspections as its primary means of collecting evidence' - and it is unclear whether this will improve oversight.

The Cabinet Office review of CQC, announced in May 2024, should consider whether the organisation has the capacity and ability to fulfil its new role. There is also a need to consider what kind of failure regime could be put in place if authorities fail, and what might trigger such a failure regime. One possible model is the criteria which Ofsted and the Department of Education use to intervene in failing LA children's services.

Health and care integration and budget pooling

Part of improving the quality of care must be ending the disconnected landscape through which users move between services. Any individual's care is likely to be funded by a range of different commissioners, who fund many different providers who are in turn responsible for hundreds of different services. Different payment models can create contradictory incentives.

The Better Care Fund is a national programme which was created as a way to bridge the historic divide between a centralised, free at-point-of delivery NHS and local means tested systems of social care. It operates through a section 75 (NHS Act 2006) arrangement.[181] It requires local authorities and health bodies to pool defined budgets for interventions which reduce non-elective admissions to hospital, and improve the timeliness of discharge from hospital.[182] But it is often used to respond to short-term problems, such as winter pressures, rather than to achieve transformation. Spending programmes can also be misaligned, when contributions to the BCF involve reallocating funds from other financial streams, over different budgeting periods.

[181] 'Review of Section 75 Arrangements: Supporting Document', GOV.UK, accessed 7 March 2024, https://www.gov.uk/government/calls-for-evidence/improving-integrated-commissioning-in-health-and-social-care/review-of-section-75-arrangements-supporting-document.
[182] Local Government Association, 'Integrated Commissioning and Provision', accessed 7 March 2024, https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund/integration-resource-library/integrated-commissioning-and-provision.

The Hewitt Independent Care Systems Review recommended simplifying the regulations and widening the scope of section 75 to include social care, third-sector providers and the full range of primary care services.[183] One challenge is the lack of transparency from LAs over how they spend BCF money. NHS interviewees expressed concern to us that cash-strapped councils could be channelling the money into maintaining basic services. Local authority interviewees said that successful pooling is too reliant on individuals building good personal relationships.

Good quality data, and the ability to share data, will be an essential part of improving collaboration going forward.

[183] Hewitt Patricia, 'The Hewitt Review' (Department of Health and Social Care, 4 April 2023), 78–79, https://assets.publishing.service.gov.uk/media/642b07d87de82b00123134fa/the-hewitt-review.pdf.

5. Empowering the Citizen

Recommendation:

Help citizens to choose and co-design their own care by expanding direct payments and improving information

The social care system is confusing and complex, and families are often left to make crucial decisions on their own, sometimes in crisis. Users struggle to get a clear picture of what services are available, and of fees. Commissioners may also have only a partial picture, when so many users are self-funders outside of their orbit.

Quality improvement in both residential and domiciliary care relies largely on the motivation of frontline staff, and their organisation's capacity. There are only a few features which are known to influence quality in residential care: the presence of an experienced registered manager, for example, and a high prevalence of self-funders.

There has been little improvement among a long tail of low performers. 3% of care homes and 3% of community settings have only ever received a CQC rating of 'requires improvement'.[184] A further 8% of care homes and 5% of community care settings seem unable to sustain improvement over time, falling back to 'inadequate' or 'requires improvement' categories after achieving a 'good' or 'outstanding' rating.[185]

Improving consumer choice could be one way to improve quality: but in this quasi-market, consumers have little power. In the care home market, both the Competition and Markets Authority (CMA) and Citizens Advice Bureau (CAB) have identified insufficient power for the consumer.[186] There are few vacancies in many areas, and some providers are pulling out. The process of arranging a care home place is usually

[184] CQC, 'Some of the Poorest Quality Services Were Struggling to Make Any Improvement - Care Quality Commission', 12 May 2022, https://www.cqc.org.uk/publications/major-report/soc201920_1e_poorest-services-struggling-to-improve.
[185] CQC.
[186] Competition & Markets Authority (CMA), 'Care Homes Market Study: Final Report', 30 November 2017.

done under extreme time pressure - over half (55%) of CAB survey respondents reported that the whole process of arranging a care home place took less than a month, and nearly one in ten (8%) reported that it took less than a week.[187] Just under half (49%) reported finding the process of arranging a care home place distressing.[188]

Barriers to empowering the citizen

1. Belief that older people don't want choice, or independence

There is a strong view in many local authorities that older people are less likely to want choice and control than younger ones, especially in the wake of a stressful experience like leaving hospital.[189] While this may be true for some, it is not borne out by the behaviour of self-funders. In one study in a single county authority, which showed a marked difference between what people being discharged from hospital wanted, and what practitioners wanted: the large majority of individuals wanted to go home, but almost half of health and social care practitioners did not want them to.[190]

2. Information Asymmetry

Elderly care is difficult to navigate. There is no consumer equivalent of *Which?* or *Trip Advisor* for these services. The most comprehensive information comes from the CQC quality ratings, but these can quickly become out of date, with the churn in the market for domiciliary care an exacerbating factor. In addition, care providers report that one problem with Amazon-style reviews is how to ensure that comments are from genuine service users, and how to get enough reviews.

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[187] Lizzie Greenhalgh and Temi Ogunye, 'Taking Greater Care: Why We Need Stronger Consumer Protections in the Care Home Market' (Citizens Advice, November 2016), 3, https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/FINAL-CitizensAdvice-Takinggreatercarereport.pdf.
[188] Greenhalgh and Ogunye, 3.
[189] Deborah Brennan et al., 'The Marketisation of Care: Rationales and Consequences in Nordic and Liberal Care Regimes', *Journal of European Social Policy* 22, no. 4 (October 2012): 384, https://doi.org/10.1177/0958928712449772.
[190] Care Quality Commission, 'Discharging Patients', 21 October 2022, https://www.cqc.org.uk/publications/major-reports/soc202021_02d_discharging-patients.

The Care Act 2014 placed a duty on local authorities to provide information, advocacy and advice services to all individuals with a need for care, whether state- or self-funded.[191] But many struggle. A FindMeGoodCare website, funded by the DHSC, was closed after two years due to the growth in other online directories. But many are simply advertorials.

Charging practices in care homes can be confusing and unexpected. More than a third (36%) of CAB survey respondents were not given a copy of the care home contract until after the resident had moved in, or were not given a contract at all.[192] 20% reported having experienced an unexpected additional charge, like a back-bill or an unexpected top-up fee.[193] Better regulation is needed to make service charges and fees transparent.

3. **Fear of reprisals**.

Residential care is usually a final choice which families are reluctant to re-open, given the anxiety which would be associated with moving to unfamiliar surroundings.[194] Only a fifth of respondents who express concerns about a care home provider go on to make a complaint.[195] The most common reason given for not making a complaint is fear that doing so would result in negative treatment from the care home.

4. **Families don't plan ahead**.

There is a reluctance to think about future care needs. One survey found nearly 4 in 5 (78%) of over-45s saying 'they had not thought about care, planned for it or spoken to

[191] UK Parliament, 'Care Act 2014' (2014), sec. 4, https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted.
[192] Lizzie Greenhalgh and Temi Ogunye, 'Taking Greater Care: Why We Need Stronger Consumer Protections in the Care Home Market' (Citizens Advice, November 2016), 3, https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/FINAL-CitizensAdvice-Takinggreatercarereport.pdf.
[193] Greenhalgh and Ogunye, 4.
[194] Christine Corlety Walker, Angela Druckman, and Tim Jackson, 'A Critique of the Marketisation of Long-Term Residential and Nursing Home Care', *The Lancet: Healthy Longevity* 3, no. 4 (21 March 2022): 299, https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(22)00040-X/fulltext.
[195] Greenhalgh and Ogunye, 'Taking Greater Care: Why We Need Stronger Consumer Protections in the Care Home Market', 4.

family about it'.[196] Among those aged-75+, 83% had not 'thought, planned, or spoken to family about care'.[197] Many people leave care planning until it is too late and then – despite their intentions – children can end up picking up responsibility. A survey by Just Group found that one in four over-45s (25%) has needed to help a parent, in-law, or partner with finding residential care.[198]

Possible ways to empower the citizen

1. **Make more use of direct payments.**

Direct payments can provide people with more autonomy and choice. Yet while the use of direct payments is around 40% among younger adults, it is only 17% for older people[199].

Both the NHS and local authorities assess individuals' needs and allocate personal budgets to fund services to meet those needs. The NHS has personal health budgets (PHBs) while local authorities use a similar tool called personal budgets.[200] Both the NHS and local authorities provide the opportunity for individuals to choose to receive their PHBs or personal budgets as direct payments. In the case of the NHS PHBs, direct payment monies must be spent according to a personalised care and support plan that has been agreed by both the care user and the local NHS team.[201] In Q4 of 2021-2022, 22% of PHBs were delivered as direct payments in England.[202] In the case of local

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[196] Just Group, 'Social Care: Coronavirus - Can the Catastrophe Be a Catalyst?', Care Report 2020 (Just Group, 2020), 6, https://www.justgroupplc.co.uk/%7E/media/Files/J/JRMS-IR/news-doc/2020/just-care-report-final.pdf.
[197] Just Group, 6.
[198] Just Group, 8.
[199] https://www.nuffieldtrust.org.uk/sites/default/files/2021-04/nuffield-trust-social-care-provider-market-web1.pdf
[200] NHS, 'What Is a Personal Health Budget?', nhs.uk, 9 November 2020, https://www.nhs.uk/nhs-services/help-with-health-costs/what-is-a-personal-health-budget/; NHS, 'Personal Budgets and Direct Payments - Social Care and Support Guide', nhs.uk, 11 April 2023, https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/personal-budgets/.
[201] NHS England, 'NHS England » Frequently Asked Questions about PHBs', accessed 4 April 2024, https://www.england.nhs.uk/personalisedcare/personal-health-budgets/frequently-asked-questions-about-phbs/#how-do-personal-health-budgets-fit-with-other-personalised-health-and-social-care-initiatives.
[202] NHS England, 'Personal Health Budgets: Quarter 4 2021-22', NHS England Digital, 12 May 2022, https://digital.nhs.uk/data-and-information/publications/statistical/personal-health-budgets/2021-22-q4/personal-health-budgets-q4-2021-22.

council funded personal budgets, which can also be received as direct payments, the spending must be within the care plan that has been agreed with the local council.[203] Most local councils will request evidence of how the direct payment has been spent every three months.[204]

Driven by local authority fears about how people may waste money, direct payment recipients encounter cumbersome processes and restrictions. But work by Think Local Act Personal (TLAP) with Essex County Council suggests there is scope for many more people to take a direct payment if social workers feel confident in suggesting it.[205] TLAP says that concerns that people will not spend the money on meeting their needs are not borne out in evidence."[206]

Service users would gain more control if direct payments were made simpler to access and more flexible. There is also scope to encourage peer support, using technology to connect recipients to each other, and to experts by experience, not only to make payments.[207]

In contrast to the UK, where direct payments are highly regulated with users being required to agree and provide evidence for how they have spent their direct payments, Germany has developed a light-touch approach to direct payments.[208] Given evidence that direct payments can not only improve autonomy but also quality of life, the UK should consider ways of making it easier for individuals to access and use direct payments.[209] Moving towards a lighter touch approach to direct payments could

[203] 'Personal Budgets and Direct Payments - Social Care and Support Guide', nhs.uk, 11 April 2023, https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/personal-budgets/.
[204] 'Personal Budgets and Direct Payments - Social Care and Support Guide'.
[205] Think Local, Act Personal, 'Better Direct Payments: From Insight to Action' (Think Local, Act Personal, April 2022), https://www.thinklocalactpersonal.org.uk/_assets/Reports/Better-Direct-Payments.pdf.
[206] Think Local, Act Personal, 'Better Direct Payments: From Insight to Action' (Think Local, Act Personal, April 2022), 12, https://www.thinklocalactpersonal.org.uk/_assets/Reports/Better-Direct-Payments.pdf.
[207] Think Local, Act Personal, 'Better Direct Payments: From Insight to Action'.
[208] Natasha Curry, Laura Schlepper, and Nina Hemmings, 'What Can England Learn from the Long-Term Care System in Germany?' (Nuffield Trust, September 2019), 52.
[209] Comptroller and Auditor General, 'Personalised Commissioning in Adult Social Care' (National Audit Office, 3 March 2016), 7, https://www.nao.org.uk/wp-content/uploads/2016/03/Personalised-

facilitate more older people employing friends and family as personal assistants.[210] It should, however, be recognised that lightening the regulatory oversight of direct payments in Germany has created a large informal market in the personal assistant sector.[211] To achieve this would involve changing the provision in the Care Act that specific council agreement is needed to employ a close family member to provide care.

Councils which have encouraged older people to take and manage a direct payment have found that even small things, like letting people electronically sign the direct payment contract rather than in hard copy, have saved delays. Some are providing personal assistants and micro-providers with business support and relevant care regulations.[212]

> *Bristol County Council has demystified the process for social workers by showing video clips of older people sharing their experience of taking and managing a direct payment - to tackle assumptions that direct payments don't work for older people. Practitioners are now interested in supporting older people to pool their budgets, to access activities that they share an interest in rather than attend day centres. The Direct Payment Support team also now takes much more of a personal supportive approach. Where 'red flags' are triggered about concerns over spend (appropriateness and/or overspending), a discussion takes place focused on helping the person get back on track. Similar supportive conversations happen about unspent balances, rather than a drive to reclaim every penny that is possible.*[213]

commissioning-in-adult-social-care-update.pdf; Curry, Schlepper, and Hemmings, 'What Can England Learn from the Long-Term Care System in Germany?', 51.

[210] Curry, Schlepper, and Hemmings, 'What Can England Learn from the Long-Term Care System in Germany?', 52.

[211] Curry, Schlepper, and Hemmings, 52.

[212] Think Local, Act Personal, 'Better Direct Payments: From Insight to Action', 16.

[213] Think Local, Act Personal, 22–23.

2. **Improve information.**

CQC's ratings should be publicised more widely. There should also be the equivalent of the NHS Friends and Family Test, which asks patients whether they would recommend the service to their friends and family, in social care. This could potentially be done through an NHS/Care app.[214]

3. **Review the role of care navigators.**

In Japan, every older person needing long-term care is assigned a "care manager" responsible for designing, monitoring and overseeing care plans and providing people in long term care with a designated point of contact.[215] Research by the Nuffield Trust suggests that having this designated care manager be a clearly defined and standardised role helps Japanese people navigate the at times fragmented and complex systems.[216]

In the UK, care navigators, sometimes called "care coordinators", provide a bridge between primary care, community health services, and social care. 90% of CCGs reported using care navigators in 2019, though implementation is variable according to findings published in the British Journal of General Practice.[217] Some evidence points to this group improving care and empowering users to make care decisions. In West Wakefield, 97% of patients surveyed were happy with the care navigation service which it pioneered between 2015 and 2017.[218]

Though care navigators are a relatively new innovation, there is already promising evidence that they could improve outcomes for care users. A 2021 overview of eleven

[214] NHS England, 'Friends and Family Test (FFT)', nhs.uk, 14 August 2018, https://www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft/.
[215] Natasha Curry, Sophie Castle-Clarke, and Nina Hemmings, 'What Can England Learn from the Long-Term Care System in Japan?' (Nuffield Trust, 2018), 19 & 36.
[216] Curry, Castle-Clarke, and Hemmings, 36.
[217] Stephanie Tierney, Geoff Wong, and Kamal R Mahtani, 'Current Understanding and Implementation of "Care Navigation" across England: A Cross-Sectional Study of NHS Clinical Commissioning Groups', British Journal of General Practice 69, no. 687 (October 2019): 679, https://bjgp.org/content/bjgp/69/687/e675.full.pdf.
[218] Richard Peter Johnson, 'Exploring Care Navigators Experience of Role' (LSBU, 2017), 15, https://openresearch.lsbu.ac.uk/download/3666bfc012741225ef55a65ba3f558604f1ec680ebff7b1e9ecee2a3798fc8db/2101569/Amended%20Full%20Thesis%20June%2021%20A.pdf.

systematic reviews identified growing evidence that care navigators improved outcomes in transitional care and for people with chronic conditions and multimorbidity.[219] Research from Canada found that care navigators improved outcomes for older patients with hip fractures in transitional care.[220] Other emerging evidence on care navigators suggests that they may support preventative healthcare by increasing access to healthcare and increasing screening rates.[221]

4. Enable advance planning

Families need clearer advice on how to plan for possible care needs. Advance planning would be helped by the creation of a clear, long-term funding settlement for social care.

5. Improve price transparency

Greater clarity over care home fees would help to inform consumer choices. Australia has appointed an Aged Care Pricing Commissioner, an independent statutory office holder whose mandate is to *"increase the level of transparency in the pricing of residential aged care services and ensure that aged care recipients are charged appropriately through approval of prices beyond the maximum set by the federal government."*[222]

In so doing, the Pricing Commissioner reviews and approves proposed accommodation payments and applications for changes in extra service fees above certain maximum

[219] Hannah Budde et al., 'The Role of Patient Navigators in Ambulatory Care: Overview of Systematic Reviews', *BMC Health Services Research* 21, no. 1 (28 October 2021): 1166, https://doi.org/10.1186/s12913-021-07140-6.
[220] Lauren Cadel et al., 'Recommendations Made by Patients, Caregivers, Providers, and Decision-Makers to Improve Transitions in Care for Older Adults with Hip Fracture: A Qualitative Study in Ontario, Canada', *BMC Geriatrics* 22, no. 1 (7 April 2022): 291, https://doi.org/10.1186/s12877-022-02943-6.
[221] Katherine B. Roland et al., 'Use of Community Health Workers and Patient Navigators to Improve Cancer Outcomes Among Patients Served by Federally Qualified Health Centers: A Systematic Literature Review', *Health Equity* 1, no. 1 (August 2017): 61–76, https://doi.org/10.1089/heq.2017.0001.
[222] Sarah Barber, Luca Lorenzoni, and Paul Ong, 'Price Setting and Price Regulation in Health Care: Lessons for Advancing Universal Health Coverage' (OECD & WHO, 2019), 23, https://www.oecd.org/health/health-systems/OECD-WHO-Price-Setting-Summary-Report.pdf.

levels.[223] The Aged Care Pricing Commissioner also provides an annual report on the state of the care provider market which details the number of residential care rooms at each price range, ensuring a high level of transparency.[224]

[223] Australian Government Aged Care Pricing Commissioner, 'Aged Care Pricing Commissioner Annual Report 2021-2022', 2022, 2, https://www.ihacpa.gov.au/sites/default/files/2023-09/Aged_Care_Pricing_Commission_Annual_Report_2021-22.pdf.
[224] Australian Government Aged Care Pricing Commissioner, 5.

6. Long-term care funding options

Recommendation:

Create a comprehensive, sustainable and transparent funding plan which pools risk nationally, with national eligibility criteria and a wide base of contributions: underpinned by a narrative which explains the public benefits of investment in social care

Reforming social care funding is not simply a dry technical exercise: it has to bring the public along with it. The dramatic ageing of populations is forcing rich countries the world over to find ways to review social contracts to older generations, without overly burdening younger generations. Japan, Germany and Australia - which we look at in this chapter - seem to have all built public trust in new systems which enhance security in later life.

In the UK, social care comprises a patchwork of different services provided by different system actors and funded through a combination of central government grant to local authorities, locally raised revenue including council tax and the social care precept, and private spending by individual "self-funders".

The question of where to draw the line between what is considered a primary health need and what counts as social care is contentious. The NHS is funded through general taxation and free at point of use. Social care is means-tested, and budgets sit with local authorities. Care home residents with more than £23,250 in capital in England and Wales[225] are not eligible for local authority support.[226] Currently, around 46% of care home residents are self-funders.[227] In 2020, private spending on social care was

[225] Scottish over-65s are also entitled to free personal care
[226] David Foster, 'Paying for Adult Social Care in England' (House of Commons Library, 29 April 2022), https://researchbriefings.files.parliament.uk/documents/SN01911/SN01911.pdf.
[227] Ilse Bosch and Ruthe Isden, 'Adult Social Care and the NHS: Two Sides of the Same Coin | NHS Confederation', 22 September 2023, 3, https://www.nhsconfed.org/publications/adult-social-care-and-nhs.

estimated to be £8.3 billion.[228] Broadly, four issues characterise the UK's provision of long-term care.

1. **Lack of a clear and coherent care package**. Social care recipients must stitch together support by applying to different programmes with differing eligibility criteria. The result is an opaque, arbitrary and unfair system. Almost half of care home residents pay their own fees and subsidise residents with fewer resources, because local authorities have been starved of cash. Continuing Health Care (NHS) budgets are the subject of court cases from people desperately battling to prove they have a 'primary health need', of which there is no strict legal definition.[229]

2. **Longstanding underfunding**. Between 2010/2011 and 2018/2019, public spending on adult social care decreased from £21.5 billion to £21 billion.[230] That period also saw an increase in demand, resulting in considerable unmet need.[231] Public spending on adult social care rose during the COVID-19 pandemic to £24.5 billion in 2022/23 according to the House of Commons Library.[232] However, the system continues to be underfunded relative to the level of capacity needed.

3. **Destabilising fee rates.** A knock-on effect of underfunding has been that some local authority fees are now so low that some providers are now charging more

[228] David Foster, 'Funding for Adult Social Care in England' (House of Commons Library, 21 February 2024), https://researchbriefings.files.parliament.uk/documents/CBP-7903/CBP-7903.pdf.
[229] Cate Searle, 'Back to Basics: NHS Continuing Healthcare Eligibility', Communities - The Law Society, May 2022, https://communities.lawsociety.org.uk/may-2022/back-to-basics-nhs-continuing-healthcare-eligibility/6002314.article.
[230] Institute for Government, 'Performance Tracker 2023: Adult Social Care', Institute for Government, 30 October 2023, https://www.instituteforgovernment.org.uk/publication/performance-tracker-2023/adult-social-care.
[231] The King's Fund, 'Demand for Adult Social Care Hits Record High While Support from Local Authorities Drops', The King's Fund, 2 March 2023, https://www.kingsfund.org.uk/insight-and-analysis/press-releases/demand-adult-social-care-hits-record-high-support-local-authorities-drops; Bosch and Isden, 'Adult Social Care and the NHS', 21.
[232] David Foster, 'Funding for Adult Social Care in England' (House of Commons Library, 21 February 2024), https://researchbriefings.files.parliament.uk/documents/CBP-7903/CBP-7903.pdf.

to people who fund their own care. The Competition and Markets Authority (CMA) reported in 2017 that self-funders paid on average 41% more for their residential care than local authority funded individuals receiving care in the same care homes.[233] Care England reported that as of April 2022, the mean difference between the fees paid by local authorities and the fair cost of care for residential care was £218 per week, and £231 per week for nursing care.[234]

4. **Sporadic, short-term injections of money.** The funding pattern is short-term and characterised partly by last-minute injections of extra cash, which leave local authorities and providers unable to plan effectively. As described in Chapter 1, the tendency to inject last-minute funds to free up hospital beds has not been a cost-effective use of money.

A new vision is needed for a coherent funding settlement which can provide long-term certainty. The exact amounts required will depend on the vision for the service. In 2019, the Health Foundation estimated that public expenditure on adult social care must increase to £31.8 billion by 2023/2024 simply in order to restore the same level of access to services that the public enjoyed in 2010/2011.[235] In 2023, the Health Foundation reported that an estimated additional £14.6 billion (in real terms) would need to be spent on social care in England by 2032/2033 just to meet future demand and cover the full cost of care.[236]

The conversation with the public has barely begun

UK politics has been at a stalemate on this issue for more than a decade, despite repeated promises by different administrations. In 2010, Labour's proposal to create a

[233] Competition & Markets Authority (CMA), 'Care Homes Market Study: Final Report', 30 November 2017.
[234] 'Fair Cost of Care Analysis - Care England', 2 March 2023, https://www.careengland.org.uk/fair-cost-of-care-analysis/.
[235] Ben Gershlick et al., 'Health and Social Care Funding: Priorities for the next Government' (Health Foundation, 23 November 2019), 16, https://www.health.org.uk/sites/default/files/2019-11/GE03-Health%20and%20social%20care%20funding%20-%20long%20read.pdf.
[236] Giulia Boccarini et al., 'Adult Social Care Funding Pressures - The Health Foundation', 25 September 2023, https://www.health.org.uk/publications/long-reads/adult-social-care-funding-pressures.

universal social care entitlement funded through a new levy on inheritances was abandoned after being branded unfair.[237] In 2022, the Conservatives abandoned their plan for a Health and Social Care Levy, over concerns that raising National Insurance would overly burden young workers in comparison to the elderly. Part of the problem has been very low awareness of social care among voters. In 2017, Theresa May was forced to U-turn on a bold manifesto pledge, because many voters were outraged to discover for the first time that they would not simply be able to rely on the NHS.

Social care has suffered from being far less visible than the NHS, to voters, politicians and the media. Even during the Covid-19 pandemic, most focus was on care homes - there was little understanding of the role of domiciliary care. Pressure from the media tends to centre on hospitals and NHS funding, and the Treasury has been reluctant to commit additional funds to social care when it has repeatedly had to fund the NHS through winter pressures. There has been no concerted attempt to explain to the public why social care spending can be a positive investment in society - and how they themselves would benefit.

One political challenge in this debate is the belief among many older people that they have paid enough tax and National Insurance to cover their costs in old age. Every single country with a "pay as you go" welfare system is now colliding with the cruel reality of ageing societies with shrinking younger generations. Intergenerational equity demands that a new settlement is not funded simply by higher taxes on working-age people.

Another sticking point is housing. The political refrain has often been that "no one should have to sell their home to pay for social care." But while the desire to pass on a home to the next generation is strong and legitimate, it may not be sustainable to ignore the value of most people's largest asset, when assessing their wealth.

[237] Watt and correspondent, 'Spectre of "death Tax" Haunts Andy Burnham's Care Revolution'.

There is an anomaly in how local authorities assess wealth in the means test. The value of the primary residence is not classified as assessable wealth for domiciliary care, meaning that people can be entitled to considerable public support despite owning an expensive home, if they have sufficiently low income and liquid savings. Yet someone who goes into residential care and owns their own home, but has no partner or dependent living there, may well end up paying the full cost of their care if their stay in residential care is not classed as temporary.[238]

This has two perverse effects. It means that two people might have very similar levels of disability and wealth, but one may be forced to pay for their care and the other not. And it provides an incentive for local authorities to nudge individuals into residential care as early as possible, so that they become responsible for paying for their own care.[239]

In the UK, this conversation has barely started. But it is now urgent. The public may also be more willing to listen. The Covid-19 pandemic improved public awareness of what social care is, and what care workers do. As more and more people see relatives needing care, or need help themselves, it has become more widely apparent that the current funding system is manifestly unfair. And there is a strong degree of cross-party agreement that the system is in crisis.

Technocratic exercises have failed. What is required now is empathetic, eloquent political leadership to make their case for a new universal settlement.

Pending reforms which the next government will inherit (for England and Wales)

The next government will inherit three substantial reforms which have not yet been implemented. These are as follows:

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[238] 'Care and Support Statutory Guidance' (2023), https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#AnnexB; David Foster, 'Paying for Adult Social Care in England' (House of Commons Library, 29 April 2022), https://researchbriefings.files.parliament.uk/documents/SN01911/SN01911.pdf.

[239] Lillie Wenzel et al., 'Approaches to Social Care Funding', Health Foundation working paper, Working Paper Number: 2 (The King's Fund, February 2018), https://assets.kingsfund.org.uk/f/256914/x/f4effc05b9/approaches_to_social_care_funding_2018.pdf.

1. **A cap on care costs.** The cap was proposed in July 2011, by the independent Commission on Funding of Care and Support, chaired by Sir Andrew Dilnot.[240] Accepted in principle by the coalition government (at a level of £75,000 rather than Dilnot's proposed £35,000), this was legislated for in the 2014 Care Act.[241] It aimed to set a maximum amount that anyone would have to pay for their personal care over their lifetime, irrespective of age or income. Implementation was initially postponed from 2016 to 2020, and then postponed to October 2025.[242]

2. **Reform of the social care means test.** In 2015, the government proposed to make the means test more generous for accessing local authority funding. The upper capital limit (the threshold of eligibility for local authority support) would increase from £23,250 to £100,000.[243] The lower capital limit (below which there would be no need to contribute towards care costs =out of capital) would increase from £14,250 to £20,000.[244] The government estimated, based on implementation in October 2023, that the proportion of older people in care receiving support from the state would increase from around half to around two-thirds as a result of this reform.[245] Like the Dilnot cap, this reform was postponed to 2025.[246]

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[240] Commission on Funding of Care and Support, 'Fairer Care Funding: The Report of the Commission on Funding of Care and Support', July 2011, https://webarchive.nationalarchives.gov.uk/ukgwa/20130221130239/https:/www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf.
[241] UK Parliament, 'Care Act 2014' (2014), https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted.
[242] David Foster, 'Proposed Adult Social Care Charging Reforms (Including Cap on Care Costs)' (House of Commons Library, 22 November 2022), 12, https://researchbriefings.files.parliament.uk/documents/CBP-9315/CBP-9315.pdf.
[243] David Foster, 6.
[244] David Foster, 'Proposed Adult Social Care Charging Reforms (Including Cap on Care Costs)' (House of Commons Library, 22 November 2022), 6, https://researchbriefings.files.parliament.uk/documents/CBP-9315/CBP-9315.pdf.
[245] Prime Minister's Office, Cabinet Office and Department of Health and Social Care, 'Build Back Better: Our Plan for Health and Social Care', GOV.UK, 8 March 2022, https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care.
[246] Simon Bottery, 'Reform Of Adult Social Care: Vanishing Over The Horizon', The King's Fund, 13 April 2023, https://www.kingsfund.org.uk/insight-and-analysis/blogs/reform-social-care-vanishing-over-horizon.

3. **A 'Fair Cost of Care' reform**. This is intended to address the market failure which stems from local authorities using their purchasing power to obtain lower fee rates from care providers, which do not adequately cover costs. According to Care England, local councils underfunded care providers by more than £2 billion in FY 2021/2022 (before inflation).[247] DHSC guidance defines the fair cost of care as the median actual operating cost for providing care in the local area plus a "reasonable" profit (including re-investment) or surplus.[248] Building on provisions in the Care Act 2014 (section 18(3)), these reforms would permit self-funders to ask their local authority to arrange their care in a care home in order to benefit from lower rates. As part of the Fair Cost of Care policy proposal, it was announced that £1.4 billion would be made available to local authorities over the following three years to assist them in increasing the rates they pay to providers where necessary, conditional on local authorities demonstrating that they have undertaken preparatory work to agree a fair cost of care with care providers before they are eligible to receive funds.[249]

All of these proposals have merit. Uprating the means-test is arguably overdue. The fair cost of care reform could help to improve market stability. The cap would protect some families - though relatively few - from catastrophically high care costs.[250] But all of them should be considered by the next government in the context of its overall vision for social care, what comprehensive overall funding settlement it can achieve, and where it

[247] 'Fair Cost of Care Analysis - Care England', 2 March 2023, https://www.careengland.org.uk/fair-cost-of-care-analysis/.
[248] 'Market Sustainability and Fair Cost of Care Fund 2022 to 2023: Guidance', GOV.UK, accessed 22 February 2024, https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance.
[249] Department of Health and Social Care, 'Market Sustainability and Fair Cost of Care Fund: Purpose and Conditions 2022 to 2023', GOV.UK, 16 December 2021, https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023/market-sustainability-and-fair-cost-of-care-fund-purpose-and-conditions-2022-to-2023.
[250] Andrew Dilnot, 'Fairer Care Funding: The Report of the Commission on Funding of Care and Support' (Commission on Funding of Care and Support, July 2011), https://webarchive.nationalarchives.gov.uk/ukgwa/20130221130239/https:/www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf.

feels the funding balance should fall, between individuals and the state. The fair cost of care reforms would require councils to carry out many more care assessments than they do now – at a time when many already have waiting lists - and would face the challenge of obtaining accurate information about the marginal costs of commercial providers. The cap could be politically difficult to sell, because it excludes spending on daily living, so would not actually represent the amount families might need to save. It would protect relatively few people, some of whom would be relatively well-off.

Other approaches

There is no shortage of proposals to reform social care funding, some of which raise funds through general taxation to expand what is free. The Fabian Society[251] has proposed free support for people with very significant support and clinical needs, and people disabled before adulthood.[252] The Institute for Public Policy Research has advocated a version of the free personal care which has been offered in Scotland to the over-65s since 2002.[253] IPPR estimated in 2019 that offering free personal care to all over-65s in England could save the NHS £4.5 billion a year by helping to shift patients out of hospital into the community, and proposed that it be funded by a 2% rise in income tax. Personal care is, however, a much narrower set of services than social care: so any move in this direction would need to ensure that it did not divert resources from wider social care provision. Other proposals include ring-fenced, insurance-based systems. Two countries which offer helpful lessons here are Germany and Japan.

The German and Japanese systems: long-term care as a vote winner

Germany and Japan, two societies which have experienced rapid ageing, both created mandatory long term care funding systems in the late 1980s/ early 1990s in response to public discontent. In both countries, political leaders articulated a vision of a fairer,

[251] Andrew Harrop and Ben Cooper, 'Support Guaranteed: The Roadmap to a National Care Service' (Fabian Society, 8 June 2023), https://fabians.org.uk/publication/support-guaranteed/.
[252] Andrew Harrop and Ben Cooper, 14.
[253] Quilter-Pinner Harry and Hochlaf Dean, 'Social Care: Free at the Point of Need' (IPPR, May 2019), https://ippr-org.files.svdcdn.com/production/Downloads/social-care-free-at-the-point-of-need-may-19.pdf.

more comprehensive settlement for the elderly, and built public support around a set of clear principles.

Both schemes are risk-pooling systems with a clear offer to voters: everyone must contribute, but with a guarantee of protection when in need. Contributions are made by workers, their employers and the retired.

Both systems share features which should apply to any UK system. They are transparent: they provide predictable and sustainable long-term funding; they are ring-fenced; and they build a sense of social solidarity.

While the systems were similar, analysis by John Creighton Campbell suggests that the political drivers behind their creation in each country were very different.[254] In Germany there was a sense of solidarity in the wake of re-unification. In Japan, concerns about the pressure of rapid ageing were coupled with fears of economic stagnation.

What is clear is that in both countries, politicians came to see LTCI as a vote winner. Natasha Curry of the Nuffield Trust suggests that the starting point of public and political debate was that the collective action problem not only could not be ignored - it would benefit everyone to address it.[255]

Germany's Long Term Care Insurance

The German LCTI provides access to a minimum level of care irrespective of means, with a standard needs assessment which ensures national consistency. Germans start paying into the fund when they turn 40, with their employers also contributing, and it supports disabled people of all ages.

[254] https://perspectivia.net/servlets/MCRFileNodeServlet/pnet_derivate_00001149/157-187_HOW-POLICIES-DIFFER-LONG-TERM-CARE-INSURANCE-IN-JAPAN-AND-GERMANY_Mono_26_Conrad_L%C3%BCtzeler-10.pdf
[255] Interview, December 2023

The fund itself is ring-fenced, demarcated from other areas of public spending and beyond the direct control of politicians.[256] Moreover it is legally required to be self-financing.[257] The existence of a public but strictly independent fund provides transparency and protects the public debate from short-term politicking. When liabilities exceed revenue, the independent insurance schemes can be used to explain the need for higher premiums to the public.[258]

Germans start contributing to the LTCI system when they start work, with contributions deducted from payroll and matched by employers.[259] Most employees pay into the public LTCI scheme which covers 90% of the population.[260] Civil servants and individuals with an income of €60,750 or above are covered by a mandatory private scheme which covers around 10% of the population and offers identical benefits.[261]

Unemployment insurance covers the contributions of the unemployed and means-tested social assistance is provided to those with disabilities through the local municipality.[262] Many Germans who need to live in residential care qualify for some form of social assistance: roughly 1/3 of all nursing home residents in Germany receive some form of social assistance.[263]

To access LTCI funds, residents are assessed and placed into one of five care levels based on their capacity to live independently.[264] Next, the service user will be provided

[256] Curry, Schlepper, and Hemmings, 'What Can England Learn from the Long-Term Care System in Germany?', 37.
[257] Pamela Nadash, Pamela Doty, and Matthias von Schwanenflügel, 'The German Long-Term Care Insurance Program: Evolution and Recent Developments', *The Gerontologist* 58, no. 3 (4 April 2017): 588–97.
[258] Curry, Schlepper, and Hemmings, 'What Can England Learn from the Long-Term Care System in Germany?', 37.
[259] Johannes Geyer et al., 'Long-Term Care in Germany' (National Bureau of Economic Research, November 2023), https://www.nber.org/system/files/working_papers/w31870/w31870.pdf.
[260] Natasha Curry, Laura Schlepper, and Nina Hemmings, 'What Can England Learn from the Long-Term Care System in Germany?' (Nuffield Trust, September 2019).
[261] Curry, Schlepper, and Hemmings.
[262] Johannes Geyer et al., 'Long-Term Care in Germany'.
[263] Johannes Geyer et al.
[264] Johannes Geyer et al.

with a choice of how to access their benefits depending on which care level they have been given according to the following scheme:

Table 2: Schedule of benefits provided according to 5 needs levels in Germany in 2022

	Level 1	Level 2	Level 3	Level 4	Level 5
Cash benefits	-	€316	€545	€728	€901
Benefits in kind	-	€724	€1,363	€1,693	€2,095
Nursing home	-	€770	€1,262	€1,775	€2,005

Table from Johannes Geyer et al., 'Long-Term Care in Germany' (National Bureau of Economic Research, November 2023), 18, https://www.nber.org/system/files/working_papers/w31870/w31870.pdf.

Benefits are taken as cash or in kind - service users can choose to receive a mixture of the two.[265] Alternatively, service users can receive LTCI benefits in the form of a nursing home benefit, with their insurer directly reimburses the provider of nursing care for care itself - not bed and board.[266] There is a built-in expectation that most Germans will have to make copayments to access care, including bed and board costs[267] associated with their nursing care.[268] Many Germans make copayments for additional care services beyond the minimum provided for by the LTCI.

Japan's Long term Care Insurance

Japanese residents begin paying mandatory insurance premiums once they turn 40.[269] Premiums are made through payroll deduction[270] until retirement, when deductions are

[265] Johannes Geyer et al.
[266] Johannes Geyer et al.
[267] Curry, Schlepper, and Hemmings, 'What Can England Learn from the Long-Term Care System in Germany?'
[268] Johannes Geyer et al., 'Long-Term Care in Germany'.
[269] Natasha Curry, Holly Holder, and Linda Patterson, 'Caring for an Ageing Population: Points to Consider from Reform in Japan' (Nuffield Trust, November 2013).
[270] IBM Japan Health Insurance Association, 'The Long-Term Care Insurance Program | Health Insurance System | IBM Japan Health Insurance Association', 2023, https://www.ibmjapankenpo.jp/eng/member/outline/system03.html.

made from pensions by the local municipality.[271] The level of contribution varies with income. There are five categories of LTCI premium contribution:

Table 3: Schedule of mandatory LTCI Premium contributions according to pay in Japan.

Category	Eligibility	Premium contribution	Estimated percentage of the population eligible
1	Public assistance recipients Municipal tax-exempted households and old-age welfare pension recipients	0.5* basic amount	2%
2	Municipal tax-exempted households	0.75* basic amount	29%
3	Municipal tax-exempted persons	1* basic amount	43%
4	Municipal taxpayer with total income of ¥ 2,5000,000 (around £12,700) or less	1.25* basic amount	16%
5	Municipal taxpayer with total income of ¥ 2,5000,000 (around £12,700) or more	1.5* basic amount	10%

Table from Ministry of Health, Labour and Welfare of Japan, '3. Premiums for Long-Term Care Insurance', accessed 24 January 2024, https://www.mhlw.go.jp/english/topics/elderly/care/3.html.

Elderly care can be accessed through the LTCI from age 65+.[272] The assessment of needs is based on a questionnaire centred around the activities of daily living known as the Kihon checklist.[273] This, together with a home visit report and a medical doctor's report, is reviewed by a long-term care board which finalises the assessment[274] and allocates the user to one of seven categories of need.[275]

Co-payments are generally needed to access care, with the standard co-payment rate being 10% of the cost of service.[276] However, the system is progressive in relation to income: higher-earners will pay more.[277]

[271] IBM Japan Health Insurance Association.
[272] Minoru Yamada and Hidenori Arai, 'Long-Term Care System in Japan', *Annals of Geriatric Medicine and Research* 24, no. 3 (18 July 2020): 174–80.
[273] Minoru Yamada and Hidenori Arai.
[274] Minoru Yamada and Hidenori Arai.
[275] Minoru Yamada and Hidenori Arai.
[276] IBM Japan Health Insurance Association, 'The Long-Term Care Insurance Program | Health Insurance System | IBM Japan Health Insurance Association'.
[277] IBM Japan Health Insurance Association.

Principles for a new funding settlement

It will take time to build a shared public consensus on what the social care system should offer, and how to pay for it. But building on lessons from other countries, and analysis of the UK's challenges, we suggest four principles against which proposals for any new funding settlement should be measured:

Transparent	Any new financing regime must be transparent. It must be clear what is being contributed, and by who. The current UK means-tested system is too patchy and complex to be well understood, both by those needing help and by the taxpayer at large. This does not mean that the only option is to increase general taxation and/or National Insurance, although both of these are readily understood. One aspect of the German and Japanese systems is that the public have become aware of what they are expected to contribute towards the costs of their own care, with different stakeholders paying in different amounts.[278] This required politicians to be honest: but it has paid off in greater public trust and more security for citizens.
Fair	The current system is riddled with inequalities. There is regional variation, with both care costs and ability to pay varying by postcode. Local authorities in some of the poorest areas are able to raise the least through the social care precept, yet some of them also have populations with very high needs.

[278] Curry, Schlepper, and Hemmings, 'What Can England Learn from the Long-Term Care System in Germany?'; Curry, Castle-Clarke, and Hemmings, 'What Can England Learn from the Long-Term Care System in Japan?', 2018; John Creighton Campbell, Naoki Ikegami, and Mary Jo Gibson, 'Lessons From Public Long-Term Care Insurance In Germany And Japan', *Health Affairs* 29, no. 1 (January 2010): 87–95, https://doi.org/10.1377/hlthaff.2009.0548.

	To overcome local disparities there is a strong case for a national set of eligibility criteria, with funds raised nationally and redistributed nationally, to services which are delivered locally. This is the principle seen in many successful social care insurance systems. It will also be important to ensure that a dwindling younger generation is not overly burdened. Simply increasing general taxation or National Insurance would place too much burden on the working-age population rather than those of pension-age.
Financially sustainable	Ageing populations are likely to put upward pressure on long-term social care even if preventative health is turbocharged and people are helped to remain independent for longer. It is vital that any new system is financially sustainable in the long-term. Both Germany and Japan have seen increasing demands on their systems, with the German Federal Government being forced to introduce a €2 billion subsidy in 2020 to cope with a rising cost shock.[279] But both countries have also worked to introduce an element of self-correction to make premiums, co-payments and user-cost balance out.[280] It should help reinforce financially responsible behaviours: the Australian, Japanese and German systems all incentivise home and community care.

[279] Thomas Gerlinger, 'Financial Reform of German Long-Term Care Insurance' (European Commission, May 2022).
[280] Natasha Curry, Sophie Castle-Clarke, and Nina Hemmings, 'What Can England Learn from the Long-Term Care System in Japan?', 2018, 3.

Universal, mandatory and pools risk	The right system will provide security to all, requiring contributions in line with wealth, and offering equal access according to need. must be underpinned by mandatory contributions. Voluntary schemes will not achieve this. Only a universal, mandatory system will work: and this will require extensive communication from politicians to win public support.

7. Conclusion

Improving outcomes for the over-65s will require a concerted effort by many actors, but most of all by central government. Sustained political leadership is needed to drive through greater integration of the health and care systems, improve incentives, and articulate a compelling vision of a better old age, with a new funding settlement for social care, which can win public support.

The public is ready for a new conversation. Confusion about social care has historically undermined debate. In 2021, Engage Britain found that 54% of survey respondents did not know whether social care was free[281], and 2018 polling commissioned by the LGA found only 15% of adults were making plans for their future care needs.[282] But the picture is changing. The COVID-19 pandemic increased awareness of care workers and what a valuable job they do. In post-pandemic polling by IPPR, 61% of respondents said the level of spending on social care was below what was needed.[283]

Action is urgent. Escalating unmet needs, workforce strains, glaring inequalities all demand a solution. It will not be possible to achieve an empowered, stable workforce without a stable care market. That in return requires a new funding settlement to support a better old age.

The interplay between the NHS and social care will remain complex. But as the NHS finally embraces technology and data-sharing there is a significant opportunity to improve the integration of health and care, become more responsive to users, and free up frontline staff to look after people.

[281] Engage Britain, 'Health & Care Survey 2021', Engage Britain, 2021, https://engagebritain.org/british-peoples-experiences-of-health-care-survey/.
[282] Local Government Association, 'Majority of People Unprepared for Adult Social Care Costs | Local Government Association', 2018, https://www.local.gov.uk/about/news/majority-people-unprepared-adult-social-care-costs.
[283] 'Care after Coronavirus: An Emerging Consensus', IPPR, accessed 6 March 2024, https://www.ippr.org/articles/ippr-policy-exchange-social-care-polling.

Fundamental to offering more fulfilling lives is a change of mindset, from “doing to” to “doing with”. There is growing evidence that quality of care improves when public sector commissioners overcome their historic distrust of independent and third sector providers.

While many of the policies elaborated in this paper are by their nature dry and technical, the goal is deeply human. In Japan and Germany, new funding systems for long term care were seen by politicians as a vote winner. The ultimate prize - improving the quality of life in old age - is hugely positive.