The case for a National Care Service (shortened version)

Jane Lethbridge
Public Services International Research Unit/ Centre for Research in Employment and Work, University of Greenwich
j.lethbridge@gre.ac.uk

Contents

Contents 1

1. What is care? 2

2. Social care reports since 1999 3

3. Current delivery of social care 4

4. A publicly, centrally funded and publicly owned NCS organised through local authorities 6

4.1 Demographic and technological change 7

4.2 Role of service planning 7

4.3 Range of care services and care providers 9

4.5 Care quality standards and controls/regulation, monitoring and inspection 9

4.6 Forms of governance, democracy and accountability 10

4.7 Seamless care and NHS integration/ NHS managers 10

4.8 Building a secure and sustainable workforce 11

4.9 Working with informal carers 11

Summary: a locally, publicly provided NCS 12

5. Approximate cost estimates 12

6. Conclusion 14

Appendix 1: Book value of equity of 5 largest care home companies 15

The case for a National Care Service

How to ensure an adequate provision of social care is a major issue facing the UK. The failure of privatised provision aggravated by the austerity inflicted upon local government and the NHS has triggered a crisis in social care. However, it is not just a question of providing enough care but about developing new and different forms of care. People are living longer lives which affect how people would like care to be delivered. Increasingly, people want care delivered at home or locally in the community in a personalised way. We will all need care at some time in our lives in the same way that we all need the NHS. Yet, there is no National Care Service.

This report sets out the how a publicly owned and publicly delivered National Care Service might operate. It starts with an analysis of the current crisis in social care and discusses the advantages that a National Care Service. This vision for a National Care Service (NCS) is based on a care service which is free at the point of access, funded through taxation.

1. What is care?

Social care is often used as an administrative term, which covers both home and institutional care. The tasks cover physical care but also include "enabling (older) people to be independent and as active as possible. The delivery of care involves some form of relationship with the older person".[1] Care services for older people and people with disabilities also contribute to: a good family life; providing protection and; supporting citizenship. As a result, a care worker plays a number of roles, which draws from a wide range of skills, as:

- Acting with commitment to an ethic of expert care;
- Developing judgement as a professional and mentor;
- Providing quality services. [2]

These are all complex and demanding roles which are not widely valued. They all demand a level of 'emotional' labour and are most often performed by women.

A National Care Service (NCS) will have to incorporate the many elements of care in a way which is sensitive and meets the needs of older people and people with disabilities. It is not just a question of delivering physical care but of creating relationships with individuals and carers and involving other members of communities so that those needing care are not left isolated and excluded. Hill *et al* (2017) outlined the phases of a care-centred approach which aims for social inclusion through the way in which care is delivered. [3] This shows that care is not just about the delivery of care but has to include needs assessment, evaluation and the incorporation of democratic practices within a service. This provides a framework for thinking about how a National Care Service would operate.

Table 1: Phases of a care centred approach

Phases of a care-centred approach	**Implications for a National Care Service – publicly delivered**
Caring about	Identifying care needs
Caring for	Accept responsibility for needs of others
Caring-care giving	Carrying out care work
Care receiving	Receiving care and judgement about effectiveness – done by services users, carers, care workers
Caring with	Meeting care needs in terms of justice, equality and freedom

Source: Hill *et al*, 2017 [4]

The ethos and values which will have to inform a new NCS and will have to address the different phases of care are:

- Leadership and partnership working;
- Training and continuous professional development;
- Imagination;
- Ways of managing so that care workers are valued;
- Supporting democratic professionalism so that professionalised workers can develop ways of working which build on principles of :
    - Listening;
    - Valuing experience and expertise of clients;
    - Importance of creating a shared language;
    - Creating new forms of expertise together;
    - Creating a shared sense of value throughout an institution or organisation. [5]

2. Social care reports since 1999

Since 1999 there have been several reports on social care commissioned by government or health and social care think tanks. They examined the future of social care but they have not resulted in any significant changes in government policy. Table 2 shows the main recommendations of these reports and government reactions to them. The creation of a National Care Service (NCS) will have to have a critical understanding of the recommendations that came from these reports and some of the barriers to their implementation.

Table 2: Social care reports 1999-2018

Report	**Year**	**Key recommendations**	**Government reaction**
Royal Commission Chair: Stuart Sutherland	1999	Free personal care (following needs assessment) funded by general taxation More generous means test - £60,000	Rejected free personal care
Wanless Report (King's Fund)	2006	'Partnership' funding for social care	
Labour Government Green Paper	2009	Proposed 'National Care Service' be set up	
Labour Government White Paper	2010	Proposed 2 year cap on paying for social care from 2014 Free at the point of use from unspecified point after 2015	Labour government post 2010 election
Commission on Funding of Care and Support (Chair: Andrew Dilnot)	2010 / 2011	Lifetime cap of £35,000 paying for social care over 65s Lowered tiered caps aged 40-65 Lifetime cap of zero for adults entering adulthood with care/ support needs or who developed an eligible need aged under 40 Lifetime cap of zero for those who had been in residential care for 2 years before cap introduced Means test upper limit £100,000 and lower	2012-2015 Coalition government proposed £72,000 cap on social care bills for over 25s Amount a local authority would have to pay to count towards the cap Upper limit of

		limit £14,250	£118,000 for those whose homes included £27,000 for those whose home not included £17,000 lower limit
Conservative government	2015	Postponed the reforms proposed by Coalition government	
Conservative government	2017	Conservative manifesto – single £100,000 limit to means test – Value of home to be included in means teat for those receiving home care Extension of deferred payment scheme to those receiving home care	Conservative minority government elected - no action taken

Source: House of Commons, 2017 [6]

All the reports published since 1999 focused on the funding of social care and the process of means-testing. One of the main arguments is whether social care should be free at the point of access. The Sutherland report (1999) concluded that the most efficient way of providing care was through the pooling of risk by "services underwritten by general taxation, based on need rather than wealth." It recommended that personal care should be free but living costs and housing would be met from people's savings and income, with the means test level raised to £60,000. However the 1997-2003 Labour government rejected this proposal for free personal care.

Initially the Scottish Executive also rejected the proposal but in November 2000 the Scottish Parliament's Health and Community Care Committee accepted that free personal care should be adopted on 'the basis of assessed need'. The 2002 Community Care and Health (Scotland) Act 2002 was passed and free care became available for people aged 65 or more from 1 July 2002. A report by the Joseph Rowntree Foundation (2007) found that the impact of making care free at the point of access had resulted in increased demand for care although this varied between local authorities. There was still widespread support for free care and people were still willing to pay more taxes to fund it. Improved systems for the collection and recording of data were needed. [7]

The establishment of a National Care Service will almost certainly trigger an increased demand for care. The failure of central government to address the funding of care can partly be explained by fears that asking for additional payments for care will result in people being affected financially. No government has yet managed to address this problem with a solution which is widely supported even though the provision of care for an ageing population is one of the biggest issues facing society today.

3. Current delivery of social care

The 2010 White Paper published by the Labour government, entitled 'Building the National Care Service', focused on providing access to free social care. Whilst ensuring access to social care which is free at the point of access is important, there is a notable silence about how care should be provided and delivered. An understanding of the reasons why funding rather than delivery dominates debates must inform the development of a National Care Service (NCS) because a new public service will have to create an ethos and vision that builds on the positive aspects of existing care provision as well as creating a new public service.

Ever since the creation of the NHS in 1948, social care provision has not been given the same status as publicly-funded health services. People with disabilities and older people unable to live independently were placed to institutions, which were inadequately funded and out of public view. By the 1970s there was a questioning of the value of institutional care and government policy recommended the closure of large institutions. By the 1980s, there was a focus on what care delivered in the community meant and how it could be delivered in a way that met individual needs. Local authorities set up residential services (group homes and hostels), day services (day centres) and more specialist services for people with complex needs or behavioural issues. [8] However, the Audit Commission's 'Making a Reality of Community Care' (1986) reported that the transfer of responsibility for community care services from health to local government had not been accompanied by any increased funding, there were no incentives for local government to develop community care services, no framework for providers and organisation to develop collaborative planning and no evaluations of effective models of community care. [9]

It was this situation which the 1991 NHS and Community Care Act attempted to resolve with the introduction of the internal market in the NHS and local government. The NHS and local government became commissioners of services from a range of providers. Financial responsibility for community care moved from central to local government but local government was discouraged from providing services, being required to contract out at least 85% of services. This resulted in local authorities contracting care services from private and not-for profit providers and a rapid decline in local government provision. During the period 1991-2018, 95% of residential and domiciliary care services were privatised.

In 2018, there is a growing consensus that the social care system is dis-functional and does not deliver care services which are needed. This is often described as a funding crisis but a major issue is the dependence on private provision. Private providers are answerable to demands from shareholders and investors before any democratic accountability to taxpayers. Private providers are demanding more funding in order to satisfy their investors and shareholders. As the care sector is a labour intensive sector, the only way in which the costs of service delivery can be reduced is through cutting labour costs and reducing the quality of services to clients. The pursuit of high returns for investors has resulted in care workers delivering services as rapidly as possible rather than delivering services which build on good communication and understanding between workers and clients, the basis for high quality care services. The problems of social care funding need to be seen as the result of the business model used by private care providers.

In 2010, the failure of the largest care provider, Southern Cross, due to high level of debt had already showed the vulnerability of depending on the private sector, as well as companies' use of debt to cover property acquisitions. The collapse of Four Seasons in March 2019 shows that the risk of private provision remains. Recent reports have examined some of the motivations behind investments in this sector. The Centre for Research on Socio-Cultural Change (CRESC) found that private providers expect a 12% rate of return on investment.[10] This is a high level and government must question whether local authorities should be contributing to such a high level of private return for a public service. The social care sector is a low risk sector because the nature of the activity changes little and so lower levels of return should be required for companies providing care services. Providers could be required, through legislation, to limit the rate of return to one or two percent. An argument against the private provision of public services is that profits in the private sector go to pay shareholders and investors rather than being invested in service improvement. A publicly funded and provided provision would be able to use surpluses to further develop and improve the services.

The creation of a market in social care has not resulted in lower prices, the balancing of supply and demand or the creation of more efficiency and effective services, which are the arguments

used to justify marketization. The care sector shows how the market has failed to deliver a public service, whether effectively, efficiently or equitably. The use of market mechanisms, specifically the purchasing and providing of care services from private providers, has resulted in a crisis of funding because shareholders and investors expect high rates of return. A growing demand for care services and austerity policies, which have affected local authorities particularly acutely, has led to further pressure on existing services, with local authorities often reducing the services they can afford to commission. An increased number of citizens are self-paying for care services or not receiving care services that they need to live independently.

At the same time, there has been an increase in the development of cooperatives, mutual and social enterprises which are considered able to deliver more locally and personally focused care. Yet, these organisations are also subject to the commissioning process and operate with time-limited contracts.

One of the main recommendations of this report is that a market is not an appropriate mechanism for organising social care. A publicly-funded and planned public service working in partnership with a range of agencies, providers and sectors would be more effective in meeting the growing demand for care. As the 2016 CRESC report concluded: "The crisis in care is ultimately a crisis of social imagination." [11]

This report sets out a basic model of public ownership/delivery and the advantages / disadvantages that public ownership would bring to the many dimensions of National Care Service. It is important to recognise that public ownership and public delivery of services necessarily involves needs assessment, planning and evaluation of service provision.

4. A publicly, centrally funded and publicly owned NCS organised through local authorities

1. Demographic and technological changes;
2. Service planning;
3. Range and type of care services and care providers;
4. Care quality standards and controls/ regulation/ monitoring and inspection of care services;
5. Forms of governance, democracy and accountability;
6. Seamless care and NHS integration;
7. Building a secure and sustainable workforce;
8. Supporting informal carers.

A publicly, centrally funded and publicly owned NCS which will be organised through local authorities providing strategic planning and delivery. This will depend on supportive strategies for recreating and revitalising local government and the replacement of the commissioning system by a local planning system. Local authorities will be responsible for planning, designing, delivering and evaluating care services. The many forms of care which are currently delivered by mainly private sector providers will be delivered from a local authority care service which will integrate residential, domiciliary and other forms of care. There will be partnership working between local authorities and education, health, housing and other public services which impact on care, some of which are also delivered by local authorities. Local authorities already have a democratic mandate but the new NCS arrangements will also build new systems of accountability for care that link them to local communities. This arrangement will provide care services so that people who need them can access them without worrying about affordability, appropriateness or availability.

There will be strong links between local authority care services and the NHS. Local workforce strategies will aim to improve the quality and standards of care and will be responsible for upgrading the existing workforce as well as creating a new cadre of care workers. Local authorities would work within National Service Frameworks for different types of care (residential/respite and domiciliary/day care) which would set national standards and priorities. These will be translated by local authorities into local targets. Similarly a national care training and care research strategy would inform the training that would take place at local authority level. Not-for-profit organisations will be encouraged, through a new system of grants, to develop new, innovative forms of care which can then be mainstreamed.

4.1 Demographic and technological change

Although life expectancy has been increasing, with women expected to live for 82.9 years and men for 79.2 years, these extra years will not necessarily be spent in good health because people develop limiting long-term conditions which affect their mobility and ability to live independently.[12] Men can be expected to live 79.7% of their lives in good health but women can be expected to live only 77.1% of their lives in good health, experiencing higher levels of limiting long term conditions than men. The consequences of the differences between life expectancy and healthy life expectancy are seen in the growing demand for care support services for older people and people with limiting long-term conditions. For people in low income groups, life expectancy and healthy life expectancy is even more reduced. Over the next 20 years the population aged 65-84 will rise by 39% and those over 85 by 106%. With a larger older population, the demand for services to provide care to people when they are not in good health will increase.

The advantages that local public provision would bring to addressing the problems of demographic change would be a local knowledge and understanding of how these changes were being experienced within the locality. A local authority would be sensitive to wider changes in demands for services. For example, if older people entered residential care at a later age when they are more dependent then interventions could be designed to provide a wider range of domiciliary support. Local authorities could be working closely with the not-for-profit sector in designing new innovative forms of care. One of the biggest advantages of local public provision would be the strength of coordination and high quality of services. This would not be subject to regular rounds of commissioning, public procurement and contract negotiation, so saving on resources. If services needed to be changed or adapted then this could be done within the scope of day-to-ay management, supported by training for workers.

Some of the problems of applying new technology to care services could be solved through a localised focus on care needs. Local care services could work, as part of a local authority economic development strategy to develop new types of care and mobility devices or develop ways of sharing data. The advantages of publicly delivered care services would be their integration into local technology strategies, making service innovation more locally focused. These activities could be formally integrated into National Service Frameworks reflecting local needs. A possible disadvantage would be how locally delivered care services could be linked to into national industrial and training policies.

4.2 Role of service planning

There are several advantages to having a National Care Service delivered at a local authority level. Local authorities have been responsible for contracting and outsourcing care services and so have an extensive understanding of the care needs of their local population. If the eligibility

for care was changed and widened, this data would need to be updated and reviewed but there is capacity for managing this type of data set and for extending and improving it.

Local, publicly delivered care services in service planning will depend on the replacement of the current commissioning system, which is based in local authorities, by a system of planning, service design and evaluation. Local authorities have responsibility for a range of public services which have to be based on the assessment of local needs. The creation of a care planning and service development department would expand the collection of data in several areas. For example the care needs of older people are closely related to their housing needs. Closer working together with housing agencies would help to inform the development of more sensitive care services. Similarly, strategies of health prevention and promotion have the potential to influence the demand for care. Working with public health departments would strengthen the ability of social care services to both anticipate future needs as well as leading to the creation of care strategies which help to change the demand for care. Again, close working with the not-for-profit sector could inform local public care provision of local communities and their specific care needs.

However, local authorities would have to be responsible for moving towards public ownership/public provision by changing from a commissioning to a planning model. An essential first stage of moving towards public ownership will have to cover:

a) Needs assessment process for local authorities which will build on existing data and also work with NHS data;
b) Mapping of existing provision of residential, domiciliary, community services. Some of this information will be available through CQC inspections and local authority contracts but less formal provision should also be identified, for example, personalisation arrangements.

The use of this data will form the basis of service planning. This will have to be done in partnership with other sectors.

This report argues that the use of a market mechanism to deliver care services is inappropriate and that the commissioning system, currently located within local government, should be replaced by a local authority planning care system which will own and deliver public care services. A publicly provided system of care would eliminate the transaction costs involved in the monitoring process of the current commissioning system. The major challenge of how to nationalise the 95% of care services which are currently privately-owned would be given to local authorities which already have a detailed local knowledge of care service provision.

Some local authorities have already introduced more stringent contract conditions with a reduction in the value of contracts which has impacted on the care sector but the current commissioning system has not facilitated the creation of new publicly owned services. Local authorities would be given the job of working with local private providers to persuade them to move into a newly establish public provision. Supported by national legislation which would make any returns on care contracts reduced to 1-2%, local authorities could start to negotiate entry into a new public service. With a new planning system, private providers, faced with a reduced rate of return, would be given the offer of public ownership through revised terms and conditions of service delivery. Existing workers would be kept on and provided with opportunities for re-grading, higher pay and re-training. This would provide an incentive for those working within care services to remain in the sector. The negotiation of the few larger care providers would have to be done by central government but in regular communication with local authorities who would be specifically affected by any care service buy-outs.

4.3 Range of care services and care providers

Table 2: Care services at local level

Type of service	Type of provision
Residential / respite (partial stays)	Local public
Domiciliary and day care	Local public
Day care to provide support and reduce isolation	Local public and some not-for-profit
Carers centres	Not-for-profit network of supported centres
Intergenerational projects – to develop interaction between older and young people	Local public/not-for-profit
Innovations – new forms of service delivery	Local public/not-for-profit
Technological care services to improve data exchange and so more coordinated care delivery and supporting independent living at home	Local public/ sectoral partnerships
Education, art, music and other forms of therapy / educational activities	Different sectoral partnerships, e.g. education, arts, adult education

This report has argued that the use of the private sector to provide care services should be reduced because the business models used by the private sector detract from improving the ways in which care is delivered. It is recognised that a private care sector will exist for higher income members of the population who wish to choose their own form of care.

For the public sector, there should be a gradual plan for establishing and developing a new public care sector, which would need to plan a transition for service providers as well as for internal changes within local authorities. The not-for-profit sector should have its remit and pattern of funding changed so that it moves away from delivering care contracts to being funded to develop, try and test innovations with a view to moving them into a new and growing public sector. The way in which the public and not-for-profit sector will work together has to build on a shared vision of how the two sectors need to complement each other to create a new NCS.

4.5 Care quality standards and controls/regulation, monitoring and inspection

To ensure that publicly delivered services deliver to a consistent public service ethos, it will still be important to set up a system of quality standards which are monitored and inspected regularly. What is needed is a system of standards which have been influenced by service users and carers and which are regularly reviewed and updated. In addition, the process of monitoring and inspecting should be one that encourages the creation of positive relationships between inspectors and public service providers. Regulation has to identify where practices should be improved but should not be seen as a punitive process.

Local, publicly delivered care services would have to be subject to a national regulation and inspection agency, similar to the Care Quality Commission. However, local Community Care Councils (set out below in Forms of governance, democracy and accountability) could provide some input into the process of setting standards.

4.6 Forms of governance, democracy and accountability

An advantage of having a NCS delivered at local authority level is that new forms of governance, democracy and accountability could be built onto existing systems of democratic representation at local level. A local authority committee for social care, which already exists in many authorities could provide a template for increasing accountability.

Community health councils from 1974 until 2003 provided support for patients and local people to contribute to monitoring NHS service delivery, working to identify service improvements and to make complaints. A similar structure will be needed to provide a framework for local communities to take part in a system of governance and accountability for a National Care Service at local level. Local people and local organisations would be elected onto a Community Care Council and would lead the work of the organisation. Each Community Care Council would have an office and workers to support its members and local people wanting to contribute to monitoring and evaluation of the NCS at local level. The aim would be to make care services accountable to local communities. People needing care and their informal carers could use Community Care Councils to communicate with local authorities and present their views of how care services are currently delivered, how to improve them and what future services might be needed.

One of the challenges for future care services is to develop a wider range of services which can be delivered locally and able to meet the needs of individuals. These would have to incorporate support for service users who already receive personal budgets. There is also a need to develop specialist services, for examples, new forms of dementia care, which can involve the voluntary, not-for-profit and even for-profit sectors. Meeting different care needs and designing future services has to be informed by a democratic process. The use of Community Care Councils could play a lead role in this process. New services could be designed to meet local needs.

4.7 Seamless care and NHS integration/ NHS managers

Local public care provision can help to extend seamless care through different arrangements which coordinate existing health and care professionals and share information at times when people need more intensive care services. A public, local provision would be able to build on existing arrangements as well as provide leadership in future arrangements. A centrally coordinated service which is not subject to different forms of ownership or contract will improve the provision of seamless care. Although the integration of health and social care is a goal in many localities, there are arguments that support the maintenance of two separate services which learn to work more effectively together. Some of the problems in the past have been linked to the different status of the NHS and social care, the problems of understanding how decisions are made and low levels of funding. A NCS locally delivered would be able to overcome some of these barriers.

In many local authorities there are already a range of teams and services which bring together health and care professionals. [13] There are already some examples of NHS and social care hubs which bring together health, social care, housing and voluntary and community organisations which work together/ alongside each to keep people at risk out of hospital e.g. West Yorkshire.[14]

Locality integrated teams bring together community and specialist nurses, therapists, social workers, GPs and relevant voluntary organisations to provide 24/7 cover to manage those patients identified as needing the greatest health and care support, typically those who have long term conditions. This provides better, more coordinated care at home.

Rapid response intermediate care brings together therapists, care staff and community nurses, working as part of the locality integrated team to provide short - term (up to six weeks) packages of support to those who would benefit from intense support back to independence. Available 8am -9pm, seven days a week, these teams support people to stay at home and avoid a hospital admission, and get people home more quickly from hospital to avoid transfer to a community hospital bed. The team will visit as often as required and provide a range of support including rehabilitation or help with tasks such as washing, cooking or visiting the shops.

Community care coordinator provides GPs, hospital clinicians and other health and social care staff with 24/7 phone and email 'single point of access' to organise specialist community services for their patients (including the rapid response intermediate care service). This makes it easier to access community services so preventing admissions to hospital and avoid discharge delays.

Community hubs will provide a local base for community staff and will help patients to access prevention services (Live Well, Stay Well), primary care services and hospital services (such as outpatient appointments, wound care or diagnostic testing) which people may have previously had to travel to. [15]

4.8 Building a secure and sustainable workforce

One of the biggest challenges facing a new publicly managed/delivered care services is the creation of a sustainable workforce, which would be professionalised, trained, well-paid and with low turnover rates. In the UK, there are 1.34 million care workers (2016-7) but 2 million will be needed by 2035. The care workforce has a high rate of turnover (27.8% in 2016-17). The number of new jobs being created has only been about 2% annually since 2013. The Department of Health issued the last workforce plan in 2009. The high level of turnover and failure to create new jobs results in inadequate standards of care. The Care Quality Commission (CQC) found that in 2017, 19% of adult social care providers required improvement and 1% were rated as inadequate. Safety is one of the areas where most improvement is needed and this is directly linked to the number and quality of staff.

A local public care service would depend on securing a sustainable workforce. It could do this in several ways. Local authority care services could work with a central government strategy to plan for a long term workforce. A new system of tertiary level further and higher continuing adult education and training work in partnership with groups of local authorities and so create a seamless arrangement for training at local level. This would help to encourage younger people to consider care work as a future profession. Care workers in training would gain experience of care delivery in different settings, similar to other health professionals. Care services could become care training/ teaching services (similar to teaching hospitals) with strong links to local tertiary level education.

4.9 Working with informal carers

A local public care service would have several advantages over existing arrangements. It would have an overall view of care and carer needs in a district. It would have responsibility for the development of innovative services and new ways of delivering services to meet the needs of carers. Local authorities would have the ability to provide training and involvement of carers/cared for to influence needs assessment and the design, delivery and evaluation of services. A local authority could build on its existing partnership work with existing carer support centres that enable carers to have regular breaks and to have a life of their own alongside their caring role, through the provision of respite care and day care centres.

Local authorities would also be able to work in partnership with employers to support carers with changes to workplace organisation and flexible working arrangements so that informal

carers can continue with paid employment. This could be part of a wider employment and skills strategy.

Local authorities are in a good position to provide support for informal carers through the reliable provision of domiciliary services. Public, locally delivered care could provide access to information about publicly owned/provided care services, health information, respite care and other forms of carer support. Working closely with existing networks of local carer centres, a more comprehensive network of care could support carers so that they no longer had to work as informal, full-time carers. The creation of local employment and skills strategies could help to create ways of supporting informal carers to remain in paid employment.

Summary: a locally, publicly provided NCS

Table 3: Advantages and disadvantages of a local, publicly delivered NCS

Advantages	Local focus which builds on existing expertise Effective at meeting the needs of a locality Local systems of accountability, e.g. Local Care Councils Care services would be able to work with housing, public health and other local government services Many local authorities have digital hubs and so care innovations could be developed with local care services
Disadvantages	Risk of not contributing to national standards unless a National Service Framework was implemented Training workforce would have to be part of a national training system although it could use local partnerships with educational institutions Similarly relationship with regional and industrial strategies would have to be made more explicit in relation to development of care economy

Table 3 sets out the main advantages and disadvantages of a local, publicly delivered NCS. The advantages build on its local focus and ability to work with other local authority departments. The disadvantages are how it would link to national training and industrial strategies and ensuring that there is a common standard of care services across the country.

5. Approximate cost estimates

Table 4: Current costs of care

Public spending	**£**	**Private spending**	**£**
Net local authority spending	£14.8 billion	Privately purchased care	£10.2 billion
User contributions	£2.5 billion	Highest cost replacement of informal care	£97 billion
Income from NHS	£1.3 billion	Lowest cost replacement of informal care	£55 billion
Other income	£0.8 billion		
Incapacity benefits and injury benefits	£28.2 billion		

Source: NAO (2018)

Table 5: Estimated costs

Estimated costs	
Cost of free personal care	Kings Fund (2018) estimated that introducing free personal care would cost **an additional £7bn** (2018 prices) in 2021 [16]
Taking private providers into public ownership	Buy-out of 6 largest care companies Current market price about £1.5b-£2b 6 x £1.5 billion = £9 billion <u>Book value</u> The book value figure is about 10% of the market value based estimate of £9bn., but (a) the £1bn-£2.5bn values for HC-One and Barchester are aspirations rather than actual sale values (b) the most recent actual sale figure seems to be the BUPA > HC-One sale of 110 homes for £300m., or £3m. per home, and the total number of Big 5 homes is about 1200, which would imply £3.6bn as a market value figure - though it obviously depends on the size of the homes. See Appendix 1 Book value 21,000 private providers – package of measures to enter public sector Part of training of staff could be covered by training costs (see below)
Developing a professionalised workforce – over 5 years	Current price of a Level 4 Diploma in Adult Care =£1,050 [17] If scope and quality of training was increased to £5,000 If all 1.35 workers were offered opportunities to train to level 4, this would cost £1.35 million x £5,000 = **£6.75 billion over 5 years** If 0.75 million new workers were trained at same level this would cost £0.75 million x £5000 = **£3.7 billion over 5 years** Total **£10.45 billion over 5 years**
Innovation and developments of different models of residential, domiciliary and community care	National Innovation Fund - local authorities to access funds **£10 million over 5 years**
Transformation of local authorities	The current costs of commissioning systems would be transferred to new planning functions of local authorities
Support for greater democratic participation in planning, monitoring and evaluating care services	Local care councils – running and staff costs **£250,000 per year / per local authority**

Table 6: Possible taxation income

Taxation	Amount raised
Raising all rates of income tax (from current levels) by 1p	£6bn
Raising employer and both employee National Insurance rates by 0.5p each	£5bn
Existing personal tax allowance thresholds and rates could raise £10bn	£10bn
A threshold of £125,000 and rates of 20% (basic rate) and 30% (higher rate)	£5bn

6. Conclusion

There are many advantages of public ownership and delivery at local level.

Advantages

- The creation of a unified system for needs assessment, planning, service delivery and evaluation
- A training strategy for the care workforce – a short and long term initiative which underpins effective and quality delivery
- Development of good practice and dissemination integrated with a national training and research strategy
- Support for carers through improved care provision and partnerships with employers through a local economic development strategy
- Democratic accountability using local Community Care Councils
- More input by services users and carers into setting of standards and monitoring of quality services
- Stronger partnerships with other public services

Disadvantages

- Local models – would have to move from existing arrangements to a new model and would require skilled leadership to create the dynamism of a new public service
- Local, public provision would have to draw on national strategies for training and research if adequate training was to be provided for the care workforce.

Society does not value care work. In order to build a National Care Service, attitudes towards older people and people with disabilities will have to change and become more positive so that sensitive, appropriate and well-funded care services are seen as central to a progressive society. Government and public services at all levels will have to take the initiative to change attitudes. More needs to be understood about what care entails. It is not just the delivery of personal care but about how people are treated, valued, enabled and empowered.

Jane Lethbridge/ j.lethbridge@gre.ac.uk
5 May 2019

Appendix 1: Book value of equity of 5 largest care home companies

(analysis by David Hall)

	Homes	%	Beds	Staff	Market value	CoHO no	Book value of share-holders equity	Sources used
HC-One	170 (+110)	2.4%	9500	11000	On sale for £1bn 2018-2019. Sold for £477m. in 2014.	**07712656**	**£20.7m.**	FT may 2018 , Carehomeprof2016 HC-One AR 2017 ; FT June 2016
Four Seasons Healthcare Holdings Ltd	343	4.9%	17000		On sale early 2019. Debt £595m. (? earlier: 2018 24 homes sold by GH for £225m; Hands bought FS for £825m. in 2012, then took £450m. write-down in 2018).	**03806216**	**£236m.**	Carehomeprof2016 FT Oct 2018 Belfast Tel Dec 2018 CoHo AR2017
BUPA Care Homes Holdings Ltd	135	4.7%	6600		Sold 110 homes for £300m. to HC-One Dec 2017	**10257786**	**£475m. (**BUPA AR 2017 £7900m, UK care revenues £750m.=6 % of £12.2bn global, so 6% of £7900m= £475m.) (Or £331m CoHo)	Carehomeprof2016 BUPA 2018 BUPA 2017
Barchester	174-200	2.8%	12000	17000	On sale 2018-19 for £2.5bn	02792285	**£122.5m.**	Carehomeprof2016 , FT July 2018 , Barchester AR 2017
Care UK	114		8000		On sale 2018. Bought in 2010 for £420m.	01668274	**-£3m. (care half of 2017 AR total figure - £6m.)**	FT may 2018 ; FT April 2018 CareUK 201718reports
TOTAL BIG 5	1230	15% (Big4)	67354				**£850m.**	Carehomeprof2016; HoC Feb 2018
Anchor-Hanover	100				Merged Dec 2018 Non-profit			CarehomeprofDec 2018
TOTAL			453000					FT may 2018

[1] Moss P. (2004) Understanding of care work in theory and practice Summary of Report on Stage Two Workpackage 11 Care Work in European Current understandings and future directions: 6

[2] Hansen H.K. & Jensen J.J. (2004) A study of understandings in care and pedagogical practice: experiences using the Sophos model in cross-national studies Workpackage 10, Summary of consolidated report Care Work in European Current understandings and future directions

[3] Hill T. *et al* (2017) Revising social inclusion to take account of care International Journal of Care and Caring 1(2): 175-190

[4] Hill T. *et al* (2017) Revising social inclusion to take account of care International Journal of Care and Caring 1(2): 175-190

[5] Lethbridge J. (2019 forthcoming) Democratic professionalism in public services, Bristol: Policy Press

[6] House of Commons (2017) Social care: Government reviews and policy proposals for paying for care since 1997 (England) Briefing Paper Number 8000 23 October 2017

[7] JRF (2007) Free personal care in Scotland: recent developments

[8] In-control (2018) Short history of social care http://www.in-control.org.uk/resources/fact-sheets.aspx)

[9] Audit Commission (1986) Making a reality of community care

[10] Burns D *et al*. (2016) Where does the money go? Financialised chains and the crisis in residential care Centre for Research on Socio-Cultural Change (CRESP) University of Manchester

[11] Burns D *et al*. (2016) Where does the money go? Financialised chains and the crisis in residential care Centre for Research on Socio-Cultural Change (CRESP) University of Manchester

[12] National Statistics https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2015to2017

[13] Buckinghamshire https://www.buckshealthcare.nhs.uk/Getting%20involved/Full%20pilot%20proposal%20Feb%2017%20FINAL.pdf

[14] https://www.england.nhs.uk/integratedcare/case-studies/nhs-and-social-care-hub-helps-people-at-risk-stay-well-and-out-of-hospital/

[15] Buckinghamshire https://www.buckshealthcare.nhs.uk/Getting%20involved/Full%20pilot%20proposal%20Feb%2017%20FINAL.pdf

[16] Bottery S. Varrow M. Thorlby R. Wellings D. (2018) A fork in the road: Next steps for social care funding reform The costs of social care funding options, public attitudes to them – and the implications for policy reform King's Fund/ Health Foundation

[17] Kingsmill D. (2014) The Kingsmill Review: Taking Care An independent report into working conditions in the Care Sector Labour policy forum https://www.policyforum.labour.org.uk/uploads/editor/files/The_Kingsmill_Review_-_Taking_Care_-_Final_2.pdf