Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

1.1. The Centre for Care proposes that it is essential for a 10-Year Health Plan to incorporate plans for a sustainable social care service which works in partnership with health and other agencies to promote people's wellbeing and independence including high quality care and support, good quality employment, and support for unpaid carers. Social care has long been treated as a 'poor relation'[1] of the NHS - not afforded the parity of esteem in terms of societal status, government funding, or workforce pay and conditions.

In order for the 10-Year Health Plan to be successful, we believe that it will be essential to:

- **Address the social care workforce crisis**; social care needs a long term workforce strategy comparable to the NHS People Plan. All too frequently, care work is characterised as 'low skill' or 'low value' and this must be challenged by those in leadership positions in the health service. Integration may present opportunities for developing the care workforce by offering progression with new responsibilities, training and status attached. ADASS emphasises that 'to meet the challenges, we need a skilled and valued workforce to do this – bringing pay in line with equivalent posts in the NHS is an important first step'. Improved pay in the care sector requires increased investment in adult social care.
- **Provide greater recognition and support for unpaid carers.** We are concerned that current policy choices in health and social care rely far too heavily on unpaid carers, at the expense of their health and wellbeing - particularly in the context of increasing pressure to facilitate hospital discharge as rapidly as possible. Poorer health and emotional burnout among carers is likely to result in a greater need for NHS resources, including in primary and community health services.
- **Adopt a holistic focus on prevention**, which recognises the crucial role that social care plays in promoting people's wellbeing and independence, while reducing or delaying the need for care and support from higher cost, more intensive services such as the NHS. This should also include investigating a preventative approach to the needs of unpaid carers, for whom current care arrangements are unsustainable.
- **Focus not only on structural change (e.g. new legislation) but also on the role of culture, norms, systems and processes in achieving policy goals such as integration and personalised care**. 'Top down' approaches are unlikely to be successful if they overlook how practitioners interact across organisational boundaries. Frequently, social care is expected to 'fit in' with the organisational culture of health services, and is not valued in its own right.
- **Understand the conditions required in order for digital technologies to enhance wellbeing and inclusion, and increase efficiency.** Technology should not be seen as 'a silver bullet'. In order to be successful, technology requires additional wraparound services which may not necessarily reduce costs; without adequate investment in assessment, installation, maintenance and ongoing support to use the technology in place, devices often do not 'work' for the person receiving care or care providers. Greater attention should be paid to the contextual factors that mediate outcomes and the scalability of new initiatives. In order for ICSs to develop and deliver digital investment plans which successfully bring all health and social care

[1] https://committees.parliament.uk/publications/23319/documents/170008/default/

organisations to the same level of digital maturity depends on their ability to build relationships, trust and understanding across sectors which are highly divergent in funding, culture, and levels of fragmentation.

Long-term investment in social care is urgently needed not only to enable people to thrive, but also to ensure the sustainability of the NHS. In the words of the latest report of the House of Lords Adult Social Care Committee, "a sustainable adult social care service is an indispensable partner to the health service."

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

2.1 **Key challenges to moving care from hospitals to communities include the social care workforce crisis, as well as a lack of joined-up working between services.** As noted in the Levelling Up, Housing and Communities Select Committee report (2022) on adult social care funding, people can become 'stuck' in hospitals due to high vacancy rates in the care services which they would be discharged into. Lack of capacity in other follow up services can also be problematic - such as intermediate care, supported living, reablement services, and palliative care. Where there is 'close working' between NHS services and social care and community services, this has been found to speed up the process of hospital discharge. For example, a provider in Dorset estimated that providing 20 reablement beds saved 'almost 3,000 hospital bed days'[2]. However, as with care services more broadly, inadequate funding impedes the ability of these organisations to provide support and work alongside health services. A 2020 report by the Local Government Association (LGA) in collaboration with ADASS concluded that 'ongoing spend and investment should be directed at effective 'wraparound' rapid discharge, crisis intervention, preventing hospital admission and reablement – including making available appropriate seven-day social work, therapy, pharmacy and transport support'[3].

2.2 Alongside services like reablement, pharmacy support, and transport, supporting more people in the community requires an **adequate supply of housing which meets their needs**. This can mean that housing needs to be made accessible, e.g., through adaptations like installing hoists and lifts. Currently, people apply via the Disabled Facilities Grant (DFG), but a cap on the grant (since 2008) means that it is insufficient to meet many people's needs. A representative from the LGA has said: 'with build cost inflation, the cost of doing serious major works adaptations, it just doesn't touch the sides really so I think we really do need a significant increase in support for the DFGs from government'[4]. Delays to the adaptations can be significant; Age UK highlights the case of a couple with mobility needs who waited for a total of 3 years in order to have a shower installed in their bathroom[5].

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[2] https://www.bbc.co.uk/news/articles/c3g0nez2zejo

[3] https://www.local.gov.uk/sites/default/files/documents/LGA-ADASS%20Statement%20on%20Community%20Care%20and%20Health%20Discharge%20new.pdf

[4] https://www.bbc.co.uk/news/uk-politics-68214736

[5] https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/reports-and-briefings/health-

Delays, complexities, and lack of housing can mean that people can find themselves stuck in inappropriate residential care facilities - when they could live in the community with the right support in place. A woman we spoke to who had complex care needs told us that she was living in a care home, but

> *'I'm looking to live independently. I've got a sum of money but it's not really enough to be able to buy me somewhere big enough and adapt it and refurbish it. So, unfortunately, it's social housing, which will take time'.* Woman in her fifties, with a spinal cord injury.

2.3 The consequence of a lack of capacity in the care workforce and wraparound services increases the **reliance on unpaid carers** when people are discharged from hospital - with severe implications for unpaid carers' health and wellbeing. Our research has indicated carers have a lower level of subjective well-being compared with non-carers, and the differences between carers and non-carers widens as local authority spending on adult social care decreases.[6] The differences are particularly pronounced for carers providing more than 35 hours of care a week. Caring has been announced as being a social determinant of health recently by Public Health England.[7] Emily Holzhausen, CBE, Director of Policy and Public Affairs at Carers UK, has commented that 'unpaid carers are under more pressure to support relatives or friends who are discharged early from hospital … many are at breaking point, providing more care than ever before due to shortages in social care, long NHS waiting lists and an outdated benefit system which leaves carers in debt to the DWP'[8]. Writing in the Levelling Up, Housing and Communities Committee report, Emily Holzhausen described a carer who was supporting her husband, and had been unable to leave the house from June to November due to the shortage of care workers who could step in to provide support.

Carers themselves face barriers in accessing health services. Our research on data gathered during the COVID-19 pandemic found[9]:

- 1 in 4 carers (1 in 5 other people) were undergoing or waiting for an NHS treatment in April
- 9 in 10 carers (8 in 10 other people) had their treatments cancelled or postponed

Among those with health conditions:

-wellbeing/disabled-facilities-grant/the-disabled-facilities-grant-a-step-change-improving-delivery-of-the-disabled-facilities-grant.pdf

[6] Zhang, Y., Bennett, M. R., & Yeandle, S. (2021). Longitudinal analysis of local government spending on adult social care and carers' subjective well-being in England. BMJ open, 11(12), e049652. https://bmjopen.bmj.com/content/11/12/e049652

[7] Public Health England (2021), Caring as a social determinant of health. Findings from a rapid review of reviews and analysis of the GP Patient Survey

[8] https://www.carersuk.org/press-releases/rise-in-people-discharged-early-from-hospital-puts-millions-of-unpaid-carers-under-more-pressure/

[9] Bennett, M, Zhang, Y & Yeandle, S 2020, Caring and COVID-19: Loneliness and use of services. https://doi.org/10.13140/RG.2.2.21054.72005https://pure-oai.bham.ac.uk/ws/portalfiles/portal/101066114/Bennett_Zhang_Yeandle_2020_CARING_and_COVID19_Loneliness_and_use_of_services.pdf

- 4 in 5 carers (3 in 4 other people) did not get a hospital in-patient service they needed
- Over half of carers who needed the NHS111 service (NHS24 in Scotland) were unable to use it or decided, during the pandemic, not to access it
- Half of carers could not get an outpatient service they needed
- 1 in 4 carers needed to, but could not, access their GP.

Services accessed by carers are also increasingly under financial pressure. Carers are able to receive support through the 2014 Care Act, which stipulates that where a carer appears to need support, the local authority must carry out an assessment to ascertain '(a) whether the carer is able, and is likely to continue to be able, to provide care for the adult needing care, (b) whether the carer is willing, and is likely to continue to be willing, to do so'. However, research indicates that the pathway to accessing support is complex[10], requiring both a needs assessment and a financial assessment. Our research[11] indicates that during the pandemic in April 2020, half of carers with health conditions (2 in 5 other people) needed community services. Overall, 1 in 4 carers needing help did not get a service they needed; specifically 2 in 5 carers and others who required a psychotherapy service did not get it and 1 in 6 carers were unable to access required pharmacy services.

2.4 It is crucial that GP practices and other health services have mechanisms in place to identify carers quickly and ensure that they can access support which meets their needs. Currently, carers are still not always routinely identified or supported by health and social care professionals and many are not aware of support available to help them look after their own health and wellbeing. In particular, carers face **obstacles in accessing respite services**: demand for respite services is increasing, with the State of Caring report finding that 47% of carers felt they needed more breaks[12], but provision has nearly halved[13]. The closure of large respite provider Revitalise demonstrates the financial fragility of respite services - and industry solutions of turning to more 'light touch' types of respite care (as opposed to residential provision) and hiring volunteers 'may not be what carers want[14]'.

2.5 Alleviating challenges and enabling people to live in the community also requires moving beyond a narrow focus on efficiency to **emphasise quality of care** (which might, but does not necessarily, align with efficiency). The Health Foundation notes that 'rather than valuing [discharge to assess] simply for the capacity it frees up, it's important to embed a focus on the wider quality benefits, including patient experience'[15]. Wider quality benefits could also

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[10] https://journals.sagepub.com/doi/full/10.1177/14713012241237673

[11] Bennett, M, Zhang, Y & Yeandle, S 2020, Caring and COVID-19: Loneliness and use of services. https://doi.org/10.13140/RG.2.2.21054.72005. https://pure-oai.bham.ac.uk/ws/portalfiles/portal/101066114/Bennett_Zhang_Yeandle_2020_CARING_and_COVID19_Loneliness_and_use_of_services.pdf

[12] https://www.carersuk.org/media/xgwlj0gn/soc23-health-report_web.pdf

[13] https://www.channel4.com/news/carers-are-just-abandoned-demand-for-council-respite-care-soars-as-funding-squeezed

[14] https://theconversation.com/uk-respite-care-provider-closure-signals-a-support-system-in-crisis-242035

[15] https://www.health.org.uk/news-and-comment/blogs/improving-hospital-discharge-in-england-the-case

mean recognising the integral role that community care plays in promoting prevention. As Beverley Tarka, President of ADASS, comments, 'while the focus on people coming out of hospital is important, we need to focus more funds on keeping people independent and out of hospital in the first place so that they don't end up needing more costly and complex medical care, which is bad for them and for the public purse'.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

3.1 People drawing on care and support, unpaid carers, and the paid care workforce all need to be digitally included for technology solutions to have a positive impact. For those using care provision, being **digitally excluded** can make it difficult to access online services (such as booking GP appointments, navigating benefits, communicating with care providers).[16] Digital exclusion is often understood as either an individual skill deficit, or an infrastructural issue: research from our Centre, and colleagues in the Information School, has demonstrated that exclusion is in practice more complex. While carers often need digital literacy and access to devices and connectivity in order to support their relatives or friends who use care services, our research highlighted issues of trust in online services and a fear of 'scams' as barriers to carers' digital inclusion[17]. Preferences and around technology use, and experience with technologies are shaped by levels of trust - e.g., that the technology will function, and that data will be used and stored appropriately. Poverty levels, age, ethnicity, and rurality all impact likelihood that individuals are digitally excluded - research shows that individuals classified as "limited users" of online technology are four times more likely to come from low-income households, 1.5 times more likely to belong to Black, Asian, and minority ethnic groups, and eight times more likely to be over the age of 65[18].

3.2 Care providers have made progress towards digitising care records (and there has been some uptake of monitoring technologies), yet financial issues in the sector mean that purchasing Care Management Systems and devices, and providing training for staff, is a challenge (discussed below).

3.3 A further challenge is establishing which technologies are useful in improving care, due to a **lack of robust evidence**. There is, we have argued, a disconnect between policy promises regarding the efficiencies which technologies can achieve, and the evidence

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[16]Zamini, E.; Roussaki, A.; Sbaffi, L.; Hamblin, K. and Black, R. (2024). The digitalisation of social care in England and the implications for older unpaid carers: a constructionist thematic analysis, Journal of Medical Internet Research, 26, e60056.https://www.jmir.org/2024/1/e60056

[17] Hamblin, K., Black, R., 2024. Digital exclusion and unpaid carers in South Yorkshire. https://centreforcare.ac.uk/wp-content/uploads/2023/05/Digital-exclusion-and-unpaid-carers-in-South-Yorkshire-1.pdf

[18] Romanowski, H., Lally, C. 2024. Digital disengagement and impacts on exclusion, https://researchbriefings.files.parliament.uk/documents/POST-PN-0725/POST-PN-0725.pdf

base[19] [20]. For instance, the effectiveness of AI applications in adult social care has been found to be 'under-developed and characterised by research that is limited due to methodological issues' (2018: 7)[21], and often underplays issues of ethics and equity[22]. Evidence is available from a number of pilot studies carried out as part of the NHS Digital Social Care Programme, yet insufficient funding impedes the scaling up of technologies, as they mean local authorities and/ or care providers incurring short term financial costs. A report evaluating the programme said "many respondents suggested that further funding or resource would be needed to see this scale-up in practice" (LGA et al, 2022: 57).

3.4 In addition, when selecting technology solutions - from mainstream technologies, like Amazon Echos (used by Hampshire County Council), or specialist services, like chatbots (London Borough of Richmond upon Thames implemented a chatbot to support carers accessing their services) and monitoring devices, it is important to **involve users in design, procurement decisions, implementation, and evaluation**[23]. A research participant who uses support for his mental health conditions said: '*we want technology that will be fit for purpose and that will suit the needs of the individual rather than just buying it and then you don't use half the features*.' We also spoke to a commissioning officer whose description of an issue with a product demonstrates why involving users is important - in this case, in the design of a cup which could monitor hydration levels:

> '*They had to change the design of the cup slightly. Originally when we got them, the cup was assigned to a person and the person was going to wear a wristband. So when they picked the cut up, the wristband would then measure what was in that cup. But they discovered people with dementia didn't want to wear these bands, so they had to design it so the band was attached to the cup'* Local authority commissioning officer.

3.5 Our research emphasises that technology solutions remain dependent on **human intervention**. Efficiency claims made in policy documents or by technology organisations need to also take into account the additional labour that technology requires[24] as well as the

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[19] Wright, J. (2020) Technology in Social Care: A Review of the UK Policy Landscape. Sustainable Care: Circle.

[20] Whitfield, G., & Hamblin, K. (2022) Technology in social care: spotlight on the English policy landscape 2019-2022, *Centre for Care Working Paper 1*, Sheffield, Centre for Care.

[21] Consilium Research & Consultancy for Skills for Care (2018) Scoping study on the emerging use of Artificial Intelligence (AI) and robotics in social care, Skills for Care, London.

[22]Whitfield, G., Hamblin, K. and Wright, J. (2024). AI in Care: a solution to the 'care crisis' in England? in Paul, R.; Carmel, E. and Cobbe, J. (eds.). Handbook on Public Policy and Artificial Intelligence, Cheltenham Spa: Edward Elgar. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4687695

[23] Fischer, B., Peine, A. & Östlund, B. (2020) The Importance of User Involvement: A systematic review of involving older users in technology design. *Gerontologist*, 60: (7): e513–e523.

[24] Wright, J. (2021) "The alexafication of adult social care: virtual assistants and the changing role of local government in England". International Journal of Environmental Research and Public Health, 18(2): 812. https://www.mdpi.com/1660-4601/18/2/812
Hamblin, K. (2022) "Sustainable Social Care: The Potential of Mainstream 'Smart' Technologies". Sustainability, 14(5), 2754. https://www.mdpi.com/2071-1050/14/5/2754

impact that technology might have on job quality and skills, with an increase in new forms of work required of care staff (or unpaid carers) like interpreting data generated by monitoring devices. Investing in staff as well as the technology itself is therefore vital: resources need to be allocated towards training staff to use technologies. A manager of a domiciliary care provider told us that there is an offer of digital training from local authorities, '*the difficulty for us when we've got 100 carers spread across the whole district is that we can't afford to bring six people in to sit down at this table and do a day's worth of digital training*'. 'Wraparound' services also need investing in, like installing, fixing, and replacing technology. High levels of staff turnover are an impediment to implementing change. An NHS officer we interviewed said:

> '*If we do identify that there is funding available for [care providers] to implement a new technology to support delivery of their care services … the challenge is they might not have the staff to implement that change [and] often the staff churn can make it difficult to embed*'. NHS officer.

3.6 Further, many technology solutions rely on **interaction between staff across services**, creating tensions and increasing workload for frontline staff. At one care provider we spoke to, alerts from monitoring devices would go to an Alarm Receiving Centre (ARC), but often staff at the ARC would then ask care workers to attend to the user, instead of sending their own staff. At another care provider, care workers were not trained to lift people if they had fallen - if an alarm was pressed, they then had to contact ambulance services.

3.7 The **digital switchover** presents another challenge in making use of technologies in social care contexts. Technology Enabled Care Services (TECS) is reliant on analogue telecommunications networks, which are being replaced with digital networks - a 'switchover' announced in 2017, with a completion date currently set for 2027. While discussion has focussed primarily on the impact of the switchover on telephone landlines, these analogue systems are also used by an estimated 1.8 million people in the UK who use TECS. Initially the switchover was due to be completed in 2025 - the delay, announced by the Government in December 2023, related to 'serious incidents' including the death of two people whose TEC devices had failed subsequent to their network being switched to the digital system[25]. Ongoing issues regarding identifying which customers are 'at risk'[26] (i.e., use TECS), and share of responsibility between national and local government, telecare industry actors, and care providers[27].

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[25] Field, M. (2023). BT and rivals told to stop forcing digital landlines on elderly after safety incidents, The Telegraph, 18.12.23. Available at: https://www.telegraph.co.uk/business/2023/12/18/bt-and-rivals-told-to-stop-forcing-digital-landlines/

[26] Tims, A. (2023). UK telecoms firms told to safeguard at-risk customers in switch to digital landlines, The Guardian, 18.12.23. Available at : https://www.theguardian.com/technology/2023/dec/18/uk-telecoms-firms-told-to-safeguard-at-risk-customers-in-switch-to-digital-landlines

[27] Warrington, J. (2023). Care companies at fault in digital landline crisis, claims Virgin Media O2 , The Times, 23.12.23. Available at: https://www.telegraph.co.uk/business/2023/12/19/care-companies-not-doing-enough-to-protect-elderly-claims/

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

4.1 Although investing in prevention has been a key policy goal for many years, our analysis finds that prevention remains poorly defined, with little progress made in specifying how success can be measured, given the counterfactuals involved. The relevant statutory guidance notes that "there is no single definition for what constitutes preventative activity".[28] This lack of shared understanding makes it challenging to agree what good practice looks like.

4.2 The chronic underfunding of adult social care is a fundamental challenge to promoting preventative care. In a context of shrinking local authority budgets, our research finds the focus has been on providing services for people with existing needs, with the prevention agenda struggling to develop momentum or articulate clear policies. This highlights a fundamental paradox, which is that although prevention is likely to save resources in the long term, it is not prioritised when budgets are tight.[29] ICSs have a key role in moving forward the prevention agenda, yet face challenges in doing so - the NHS Confederation has identified 'insufficient clarity about the meaning of prevention, congruence with routine government business, and capacity to shift resource into prevention'[30]. A 2019 survey of care providers and commissioners produced by Skills for Care found that 'time pressures and financial resources … were flagged as constraining factors [of prevention activity] with the greatest regularity in the survey' [31]. The 2024 ADASS Autumn survey found a decrease in councils able to put resources towards prevention, as 'the proportion of councils taking a positive investment strategy for preventative services dropped from 44% in 2023/24 to 29% in 2024/5'[32]. Similarly, a manager of an organisation producing technology to monitor care needs, with the aim of identifying and preventing the worsening of conditions, told us that prevention simply isn't prioritised when budgets are tight; '*we just haven't got capacity to do the proactive piece that this person might need [and] as long as it's tagged with preventative, you cannot do it, because that can wait*.'

4.3 Access to services is crucial to the early identification of health conditions. Research has emphasised that individuals seeking care, and their family members, struggle to navigate the complex care system: Richard Humphries, for example, notes that 'although the old Victorian institutions that housed elderly, disabled and destitute people, with forbidding walls designed

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[28] Department of Health and Social Care, Care Act 2014 statutory guidance, https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[29] Tew, J., Duggal, S., Carr, S., Ercolani, M., Glasby, J., Kinghorn, P., ... and Afentou, N. (2019) Implementing the Care Act (2014): Building Social Resources to Prevent, Reduce or Delay Needs for Care and Support in Adult Social Care in England, Birmingham: University of Birmingham.

[30] https://www.nhsconfed.org/publications/report-unlocking-prevention-integrated-care-systems

[31] https://skillsforcare.org.uk/resources/documents/Support-for-leaders-and-managers/Integration/Prevention-in-adult-social-care-report-December-2019.pdf

[32] https://www.adass.org.uk/wp-content/uploads/2024/10/ADASS-Autumn-Survey-2024-EMBARGO-0001-6-NOV.pdf

to keep people in, have long gone, modern social care has constructed new, virtual walls that, if anything, are designed to keep people out, spawning a vocabulary of 'gatekeeping' (requiring gatekeepers), eligibility, thresholds and pathways, signposting and demand management'[33]. Often people navigate these systems in situations of emotional distress and powerlessness. Struggling to access care and system delays means that conditions have worsened by the time the person is receiving support. Some groups face additional barriers to access, for instance due to lack of interpreters[34]. The ONS found that disabled people often made '"extensive" preparations and had to develop workarounds when interacting with "difficult-to-access services"'[35]. Sometimes these difficulties relate to the digital exclusion described above: an interviewee with learning disabilities said, '*I need to look at downloading an NHS app again, because it's kind of… I lost it, the Pathway app that I had, it went funny. So sometimes it frustrates me, it just stops working*'. Accessibility issues can also make it difficult to attend health appointments. Another interviewee, who is registered blind along with her husband, told us how:

> *Our local GP surgery had one of those 'when your name is called' thing, and you'd say to them, "Can you let me know when my name comes up?" "Oh, it's on the thing." "Yes, well, I'm asking because I can't read that thing." [...] The other thing that happened was the NHS brought in this thing called the Accessible Information Standard, so, when that came in, we wrote to our surgery and said we wanted to be told about things by email. We had an acknowledgement, so Steve started to get things, a high blood-pressure appointment, a written letter. So, we phoned up the surgery and said, "Look, he can't read this letter. He wants to be told." "Oh, we can't do that, because of data protection."* Woman in her fifties, registered blind.

4.4 An enabler of identifying illnesses and worsening conditions is the **skills, knowledge, and capacity of the workforce**. Skills for Care emphasises that social care staff 'will need to develop new skills, knowledge and capabilities to deliver effective prevention and wellbeing activities', giving examples like providing advice, information, and guidance, recognising indications of poor health, and 'identifying health and other risks in a person's home or through their behaviour' as well as developing 'persuasion, motivational and effective communication' and discussing difficult topics[36]. A lack of workforce capacity affects care workers ability to engage in these activities; for instance, in very short home visits can make it difficult for staff to pick up on illnesses and worsening conditions among the people they support. A further challenge is the reliance in the sector on agency staff who are less likely to be familiar with the people they support, and therefore may struggle to identify when their health needs have changed.

4.5 Tackling the causes of ill health requires an understanding of how health interacts with inequality. The CQC's 2021/22 edition of State of Care emphasises that 'people from the

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[33] Humphries, R. (2022). *Ending the social care crisis: A new road to reform*. Policy Press, p. 11

[34] https://www.cqc.org.uk/publication/state-care-202122/inequalities

[35] https://lordslibrary.parliament.uk/challenges-faced-by-people-with-disabilities/

[36] https://www.skillsforcare.org.uk/resources/documents/Support-for-leaders-and-managers/Integration/Role-of-prevention-in-social-care.pdf

most deprived areas are less likely to access preventative care, or receive care at an early stage when their condition may not be as serious'[37]. The interactions between health and structural inequalities are emphasised in the 2024 IPPR report, 'Our Greatest Asset'[38], rather than a focus on personal responsibility for health. Instead, the authors highlight that: 'for someone balancing low paid work with financial insecurity and caring responsibilities, there is no easy way to go out for a run or afford a gym membership. For someone living on increasingly inadequate universal credit rates, the extra cost of healthy food puts good nutrition out of reach'. In addition, lack of 'healthy infrastructure' like leisure centres and parks, overcrowded and hazardous private rented housing are an obstacle to tackling ill health. In our own research, care workers described how difficult it is to eat healthily while working long hours. One worker said:

> *'Today I've had nothing to eat yet. I've got a bag of crisps in the car, whether it's in date or not is another thing, and some sweets. In care, you don't eat properly. I don't work Sundays at all and that's my day and I go with some of my other friends that are carers from here. We call it our vegetable day because we always go and have a Sunday roast*' Care worker, working at a domiciliary care company.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:
• Quick to do, that is in the next year or so
• In the middle, that is in the next 2 to 5 years
• Long term change, that will take more than 5 years

5.1 **Short term policy ideas** should focus on the immediate need to substantially improve pay and working conditions in the social care sector. It is imperative that these changes are adequately resourced - a lack of government investment puts providers under additional financial pressures which mean that they have to make cuts elsewhere or simply leave the sector. Without a sustainable workforce, care needs will be unmet or undermet - preventing early identification of illnesses, and increasing reliance on NHS services and pressure on family carers. As ADASS conclude, 'Failure to close the adult social care resourcing gap has left councils struggling to square their legal duty to set a balanced budget with their duty to provide statutory services' … 'Confirming the continuation of all adult social care grant funding and precept at the earliest opportunity, to provide certainty, confidence and continuity for councils, care providers and voluntary, community, faith and social enterprise sector organisations.'[39] Additional funding is needed to relieve immediate pressures threatening the sector in the immediate future, notwithstanding the need for agreement about how we fund and organise adult social care in the long term.

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[37] https://www.cqc.org.uk/publication/state-care-202122/inequalities

[38] https://ippr-org.files.svdcdn.com/production/Downloads/Our_greatest_asset_Sept24.pdf

[39] https://www.adass.org.uk/wp-content/uploads/2024/10/ADASS-Autumn-Survey-2024-EMBARGO-0001-6-NOV.pdf

5.2 A new co-produced National Carers Strategy is required, which takes a cross-governmental approach to delivering the breadth and depth of support needed by carers. This should include a strategic approach to identification and recognition of unpaid carers, support for carers incomes, finances, health and wellbeing, as well as placing a high priority on tackling inequalities faced by carers.The Government should dedicate ring-fenced funding to increase the availability and capacity of services that provide flexible short breaks for unpaid carers.'[40]

5.2 In the **medium-term,** in order to shift away from the reliance on unpaid carers to the detriment of their own health and wellbeing, adequate resources need to be allocated to make the aforementioned co-produced strategy actionable. The previous funding allocation for carers as outlined in the 2021 White Paper was 'merely tinkering'[41] and it has been evident that without allocated resources, the best laid policy intentions for carers are then not realised[42].

5.3 In the **longer-term**, there needs to be a sustainable, sustained funding settlement for adult social care that recognises its role in society beyond providing ancillary services to the NHS. Adult social care should be integral to ensuring people with disabilities and long-term conditions and those that support them can live lives that are fulfilling. Achieving consensus about how we fund and provide care and support should be achieved via a public dialogue which raises the profile and the status of this often invisible and undervalued work.

As Care England argues, investing in care is an investment in the economy, particularly in more deprived areas of the country; 'The solution is simple and clear. While there is debate over exactly how much adult social care requires – estimates suggest upwards of £10 billion – this investment would yield a return of £7.5 billion in additional economic benefit, particularly in the North and Midlands. This could cover more than a third of the reported £22 billion deficit. Furthermore, investing in adult social care would ease the strain on the NHS, improve population wellbeing, and strengthen local economies in North and Midlands areas.

If the government's priority is balancing the books, adult social care presents a compelling case. Redirecting funds from areas like overseas aid or defence – sectors that do not provide the same economic return – could provide the necessary capital to support adult social care. Such an investment, with its 175% ROI, would also attract further overseas investment, adding additional and greater value to the UK economy'[43]

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[40] https://publications.parliament.uk/pa/ld5803/ldselect/ldadultsoc/99/9912.htm

[41] Yeandle, S. (2021). 'Merely tinkering': expert analysis of the UK government's new plan to reform social care in England, The Conversation, https://theconversation.com/merely-tinkering-expert-analysis-of-the-uk-governments-new-plan-to-reform-social-care-in-england-172085

[42] Fernandez, J. L., Marczak, J., Snell, T., Brimblecombe, N., Moriarty, J., Damant, J., ... & Manthorpe, J. (2021). Supporting carers following the implementation of the Care Act 2014: eligibility, support and prevention: the Carers in Adult Social Care (CASC) study.

[43] https://www.careengland.org.uk/the-governments-dilemma-why-isnt-adult-social-care-a-priority-for-investment/