Homecare Association

Homecare Association Submission to the Palliative and End-of-Life Care Commission

1. Introduction

The Homecare Association is a national membership body for homecare providers, with over 2,200 members across the UK[1]. Our mission is to ensure society values homecare, and invests in it, so all of us can live well at home and flourish in our communities. We lead the way in shaping homecare and provide practical support for our members. Our members encompass the diversity of providers in the market: from small to large; state-funded to private-pay funded; generalist to specialist; live-in services to visiting services and from start-ups to mature businesses. Many of our members provide end-of-life care.

We highlight challenges and opportunities in providing quality end-of-life care at home. Drawing on workforce data, economic modelling, and recent research, we show how underfunding of homecare directly compromises the UK's ability to honour people's preferences for community-based dying while proposing actionable solutions aligned with NHS Long-Term Plan priorities.

2. Moving end-of-life care from hospitals to communities: the critical role of homecare

Homecare plays a crucial role in supporting people with advanced illness in their last months of life. Many individuals express a preference to die at home, surrounded by loved ones, and homecare workers help to facilitate this choice. However, the sector faces significant challenges in providing high-quality end-of-life care. These include funding pressures; workforce challenges; and inadequate support from health services.

The Gold Standards Framework (GSF) has shown that well-supported homecare can reduce hospital deaths. GSF accredited teams have shown a halving of hospital

deaths and admissions, with 97% of carer support and 84% of people dying in their place of choice[2].

A recent rapid review published in the British Medical Journal states: "*social homecare workers form part of an essential care network and workforce that enables people to remain at home during the last months of life".*[3] Homecare workers offer vital emotional and practical support, preventing unnecessary hospital stays.

Over 67% of individuals express preference for dying at home, yet only 44% achieve this. Homecare workers deliver 23 million hours of end-of-life care annually in England. They often act as first responders to symptom crises and provide vital continuity between formal health services[4] [5]. The SUPPORTED study at Hull University revealed homecare workers routinely manage complex interventions, including:

- Administration of subcutaneous medications via syringe drivers.
- Recognition of imminent dying signs.
- Psychological support for patients/families.

However, 78% of homecare workers report insufficient training in pain management or anticipatory prescribing. This creates dangerous reliance on emergency hospital admissions.

Challenges

1. **Funding shortfalls**. The funding gap for quality homecare makes it hard to provide reliable end-of-life care.
2. **Workforce issues**: Forward et al. (2024) found that "*compared with other professionals delivering care in this context, [homecare workers] receive less training, support for career development or remuneration*". This leads to recruitment and retention difficulties, meaning people may not receive continuity of care at a critical time.
3. **Support from health services**. Weak links between health and social care make patient transitions difficult. Communications and support from healthcare professionals is variable[6].

Funding shortfalls

Reports suggest hospitals spend £6.6 billion on emergency care for those at the end-of-life[7]. This is more than the government spends on all homecare in total (£5.282 billion)[8]. Providing more end-of-life care at home rather than hospital could

offer significant savings. The cost of one day in a hospital bed could pay for a week of homecare. Calculations suggest training three homecare teams costs less than one average hospital admission.

Despite these efficiencies, Integrated Care Boards under-invest in homecare for people at end-of-life. They pay fee rates which are too low and delay payment of invoices, risking the financial stability of providers[9] [10].

Any discussion of end-of-life care in homecare must acknowledge the parlous state of funding in the sector. Our most recent research reveals a significant and growing funding deficit that directly affects service quality, workforce retention, and ultimately, outcomes for people:

Minimum Price for Homecare 2025-26

Each year, the Homecare Association looks at the costs of homecare delivery to calculate a minimum price for homecare. This is the minimum rate a homecare provider needs to meet employment and care regulations, deliver quality services and operate sustainably. Staff costs include the National Minimum Wage (NMW) for all work hours (including travel), and statutory employment on-costs. These include statutory pension; national insurance; sick pay; holiday pay; and training time. The hourly rate also includes a contribution to other running costs. These include wages for the registered manager and office staff; recruitment; training; digital systems; telephony; insurance; regulatory fees; PPE and consumables; office rent, rates and utilities; finance, legal and professional fees; general business overheads; and a small surplus for investment.

We calculate the Minimum Price for Homecare for 2025/26 at £32.14 per hour[11]. This reflects Autumn Budget 2024 increases in the NMW and employers' national insurance contributions.

Our research in 2024 showed only 1% of public sector contracts were paying at our minimum price for 2024/25 of £28.53 per hour. The average fee rate paid across the UK in 2024/25 was £23.26 per hour[9].

Just 6% of homecare contracts with local authorities had a fee increase that kept up with the rise in the National Living Wage of 9.8% in April 2024.

There is a funding deficit for the homecare sector in England of £1.8 billion just to pay the current National Living Wage for existing hours purchased.

The Autumn Budget 2024 changes to employers' National Insurance contributions widen the funding deficit. While the government allocated £880 million in new grant funding for social care, this falls far short of requirements. The Nuffield Trust

estimated increased costs for the adult social care sector in England from the Budget measures alone of £2.8 billion in 2025/26[12].

Impact of funding shortfalls on end-of-life care

This financial context has profound implications for end-of-life care provision, as it directly affects:

- Ability to recruit and retain skilled staff.
- Capacity to provide training in end-of-life care.
- Quality and continuity of care.
- Ability to respond quickly to changing needs.

Unfunded increases in costs force providers to:

- Offer uncompetitive pay and employment conditions, exacerbating difficulties retaining and recruiting careworkers[13].
- Operate with staff vacancy rates of almost 10%[14].
- Limit homecare worker supervision to a few minutes per week vs NHS recommended 60 minutes[7].
- Cut training budgets[15].

Workforce issues

Training in end-of-life care

The SUPPORTED study identified critical gaps:

- 63% of homecare workers had never received formal end-of-life care training.
- 89% lacked access to specialist palliative advice during shifts.
- 72% reported anxiety about legal repercussions from medication errors[4] [5].

This contrasts starkly with the Gold Standards Framework's recommendation for 18 hours per year end-of-life care training per homecare worker[2].

Forward et al. (2024) identified significant gaps in training and support specifically related to end-of-life care[3]:

- Training needs include "recognising the deteriorating client, symptom management, practicalities around death, communications skills and supervision."
- Homecare workers are "*inadequately trained, often isolated and underappreciated," despite being "essential for end-of-life care at home*."
- There is a need for "*developing trusted relationships... recognising good practice in this context, and providing the right support and training.*"

Our Homecare Association Workforce Survey in 2024 confirmed broader training challenges that impact end-of-life care[13]:

- 67% of providers experience difficulty accessing funded training for their workforce.
- Over half (53%) of providers struggle to release staff for training because of workforce shortages, limiting opportunities for end-of-life care skills development.
- 45% reported that the cost of training is prohibitive, particularly for specialist areas like end-of-life care.

These findings align with the conclusion of Forward et al. (2024) that "*some training exists for homecare workers, but the most beneficial and acceptable content, delivery and implementation of training remains unknown.*"[3]

Emotional support and wellbeing

End-of-life care places unique emotional demands on homecare workers that require specific support mechanisms:

- Forward et al. (2024) emphasised that "*homecare workers need to manage complex and distressing situations, navigating their own, their clients' and clients' family, emotions.*"3.
- The emotional burden can contribute to burnout and stress, affecting both staff wellbeing and care quality.
- Our workforce survey showed that 76% of providers have implemented wellbeing initiatives to support staff, but these often lack the specialised focus needed for those regularly providing end-of-life care.
- There is a need for "*structured and unstructured support such as supervision-type processes*" as identified by Forward et al. (2024).3.

The lack of formal emotional support structures contrasts sharply with practices in healthcare settings and specialist palliative care, where supervision and debriefing are standard.

International recruitment and end-of-life care

While international recruitment has helped address some workforce gaps, it presents specific challenges for end-of-life care.

- Skills for Care reported a 7.9% increase in filled posts in England's independent homecare sector in 2023-24, largely attributable to international recruitment[14].
- However, in our Homecare Association workforce survey, 64% of providers identified language or communication issues with internationally recruited staff, which can be particularly challenging in the sensitive context of end-of-life care[13].
- Cultural differences in approaches to death and dying may require additional training and support for internationally recruited staff.
- Recent changes to immigration rules have led to a significant decrease in visa applications, threatening this source of workforce growth.

The reliance on international recruitment highlights the need for specialised induction and ongoing support in end-of-life care for workers from diverse cultural backgrounds.

Zero-hours contracts and job security

Most local authorities and ICBs buy homecare using zero-hours contracts, paying for client contact time only. This results in zero-hours employment contracts, affecting end-of-life care.

- Our survey found that 45% of homecare workers are on zero-hours contracts[13].
- This lack of job security creates challenges for consistent staffing in end-of-life situations, where continuity is particularly important.
- As noted in our previous research, "zero-hour commissioning at low fee rates leads to insecure zero-hour employment at low wage rates. It also limits other investment in the workforce, such as training, supervision and career development"[9].

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Providers reliant on state-funded contracts often have little choice but to offer zero-hours contracts because of the unpredictable nature of commissioned hours and low fee rates.

Opportunities

1. **Investments in community care**: The Decisions At Life's End (Dale) project in Leicestershire showed how an integrated approach with local teams could reduce unscheduled hospital admissions at end-of-life[16]. Increasing NHS Continuing Healthcare (CHC) funding for end-of-life care at home would increase the amount available for training and supervision.
2. **Training.** The NHS could provide training in end-of-life care for homecare workers.
3. **Digital coordination**: In 2010, an NHSMail pilot in south London showed how secure information sharing between social care teams and healthcare professionals improved coordination for end-of-life care[16]. During the COVID-19 pandemic, more care providers received access to NHSMail, which could be used to improve communication and coordination.

3. Technological enablement in community end-of-life care

Evidence on effective use of technology in palliative and end-of-life care

Technology can greatly improve end-of-life care coordination, communication, and monitoring. Examples include:

1. **Electronic call monitoring and care planning systems**: These enable real-time updates on care delivery and provide a platform for sharing information between carers, family members, and healthcare professionals.
2. **Digital support for assessment**: Forward et al. (2024) referenced the development of a "*symptom assessment solution, which aimed to help staff assess changes in symptoms and any associated decision-making, aiming to increase skills and confidence*."[3]
3. **Secure communication platforms**: The NHSmail digital project provides a secure platform for sharing sensitive information between social care teams and multidisciplinary colleagues.

Challenges

1. **Integration issues**: Forward et al. (2024) noted that "*incompatible health and social care IT systems can make communication between the various professionals involved difficult*."[3] While 77% of homecare providers now use digital care records, only a small percentage can access real-time patient health data. Some software suppliers to the care sector have introduced GP Connect.[17] Access to summary health records improves patient safety during transfers of care. Clinicians in the NHS proved resistant to sharing records in this way, regarding care professionals as inferior.
2. **Training needs**: Many homecare workers need additional support to use new technologies effectively, yet training budgets are constrained by low fee rates.
3. **Infrastructure requirements**: Not all homecare settings have reliable broadband or appropriate devices, creating a digital divide.
4. **Cost implications**: Low fee rates for homecare from public bodies leave no margin for technology investment. Making a case for a return on investment is difficult for providers because benefits may accrue elsewhere in the system. Councils and NHS commissioners often buy homecare by the minute. Focusing on time and task rather than outcomes, reduces flexibility and discourages innovation. These barriers risk perpetuating dangerous information gaps during care transitions.

Opportunities

1. **Remote monitoring**: Technologies that enable remote monitoring of symptoms can help identify deterioration earlier, potentially preventing crisis admissions.
2. **Shared care records**: Systems that allow all professionals involved in a person's care to access and update records can improve coordination and reduce duplication.
3. **Virtual support for carers**: Technology can connect informal carers with professionals for advice and guidance, enhancing their confidence in providing care.

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4. Preventive care

Evidence on how palliative care may prevent crisis

Proactive, well-coordinated homecare can prevent many crises for people at the end of life and their families. Forward et al. (2024) emphasised the importance of homecare workers in recognising deterioration and accessing appropriate support[3].

The GSF approach has shown that identifying people in their final year of life and offering advance care planning discussions can significantly reduce emergency hospital admissions and improve care experiences[2].

Holloway and Smith (2010)[18] highlighted the importance of social care in providing holistic assessment that addresses not just physical needs but also psychological, social, and spiritual dimensions, which can prevent distress and crisis situations.

Examples of preventative approaches

1. **Early identification**. Training homecare workers to recognise signs of deterioration can enable timely intervention. However, Forward et al. (2024) found that homecare workers often struggle to articulate changes they observe: "*You see a change, but you can't go on the phone and say to the doctor, 'Well she's changed,' because there isn't a word for it […] it's like a gut feeling for me*."3.

2. **Responsive care planning**. Flexible care packages that can be quickly adjusted as needs change can prevent crisis admissions. The Macmillan special spot purchasing budgets demonstrate how targeted additional support can enable people to remain at home during periods of increased need[16].

3. **Support for informal carers**. Forward et al. (2024) emphasised the importance of supporting carers to prevent burnout and crisis. Homecare workers provide crucial emotional support and respite that can sustain caring relationships[3].

4. **Advance care planning**. Early discussions about preferences help prevent unwanted interventions or admissions.

Challenges

A significant challenge is the recognition and funding of preventative approaches. Current commissioning often focuses on task-based care rather than outcomes or prevention. This is exacerbated by the financial pressures on local authorities, leading to rationing of care.

Opportunities

We need more flexible funding for preventative care. The Partnerships for Older People Projects (POPPs) evaluation suggested that investing early in support for individuals results in savings, as more intensive care is required later and for a shorter period at the end of life[16].

5. Integration

Evidence of how palliative and end-of-life care can integrate across sectors

Integration between health and social care is essential for effective end-of-life care. Thomas (2025)[2] emphasises that "for quality care for people nearing the end of life, we need BOTH well trained, generalist frontline teams AND specialists in palliative care, geriatrics, dementia etc working well together."

The West Essex joint working initiative showed how closer partnership between health and social care can improve end-of-life care delivery. This initiative established social care representatives on the End of Life Care steering group, created a joint communication plan, and integrated the Preferred Priorities for Care into social care assessment paperwork[16].

Challenges

Forward et al. (2024)[3] identified several key challenges to effective integration:

1. **Professional isolation**: "*Homecare workers are often isolated from their own teams, and usually from the wider health and social care teams.*"
2. **Lack of recognition**: "*The role of the homecare worker providing care to those approaching the end of life is one which requires flexibility and effective communication*." Yet homecare workers report feeling "*poorly understood and valued and led to them being left out of wider support and communications*."

3. **Communication barriers**: "*The changing nature of providing care for clients with progressive, advanced conditions and their families is a particular challenge in the context of end-of-life care*."
4. **Different funding mechanisms**: Transitions between social care and continuing healthcare can be disruptive for individuals and families, affecting both personal care and financial arrangements.

Opportunities

1. **Multidisciplinary training**. The GSF Cross Boundary Care ICS Events bring together professionals from across health and social care to develop a common language and understanding.

2. **Shared documentation**: The Admission Assessment Integrated Care Pathway provides an evidence-based template for assessing holistic needs across physiological, social, psychological, and spiritual domains[16].

3. **Palliative care social workers**: These specialists can bridge the gap between health and social care, providing leadership and expertise. Forward et al. (2024) suggest developing "ways in which specialist palliative care social worker educative roles can be developed[3]."

4. **Regional coordination**: The Nottinghamshire pathway for patients and carers across all conditions and settings demonstrates how strategic coordination can improve integration[16].

6. Recommendations

Based on the evidence presented, we make the following recommendations to improve end of life care in homecare settings:

Funding and commissioning

- The government must provide an immediate cash injection of £1.8 billion for homecare to cover the increased employment costs resulting from Autumn Budget decisions and previous deficits.
- Implement a National Contract for Care services that sets a minimum price for homecare to ensure public sector commissioners pay a fair price to cover fair pay and the full cost of quality care.

- Public sector commissioners must move without delay to discussing and agreeing fee rates for 2025-26 with providers, taking fair account of wage inflation and Autumn Budget measures.
- Offer greater security of hours and income to trusted providers, enabling investment in workforce and care quality.
- Move away from purchasing homecare by time and task and instead focus on outcomes.

Workforce development

- Establish comprehensive end-of-life care training for all homecare workers, as recommended by Forward et al. (2024)[3]: "*The development and evaluation of widely available training content and guidelines for supportive practice are indicated to support this vital workforce*."
- Develop structured emotional support for homecare workers dealing with death and bereavement, including supervision models similar to those used in healthcare settings.
- Create career pathways that recognise and reward expertise in end-of-life care.
- Ensure homecare workers are included in multidisciplinary team communications and planning.

Integration of services

- Implement shared electronic records accessible to all professionals involved in a person's care.
- Establish clear protocols for transitions between services, particularly between social care and continuing healthcare.
- Include homecare representatives in all end-of-life care planning at both strategic and individual levels.
- Develop joint training programmes that bring together health and social care professionals.

Technology and innovation

- Invest in secure communication platforms that enable information sharing between social care and healthcare professionals.

- Support the development and implementation of symptom assessment tools tailored for use by homecare workers.
- Ensure all homecare workers have access to the technology and training needed to participate in digital care coordination.
- Evaluate and scale successful technology initiatives, such as the NHSmail pilot.

7. Conclusion

Homecare plays a vital but often under-recognised role in supporting people at the end of life. As Forward et al. (2024) conclude[3]: "*Homecare providers provide essential care to enable end of life care at home, but need further training and support, and recognition by and inclusion with the wider healthcare team*."

The chronic underfunding of social care has created a situation where providers struggle to recruit, retain, and develop staff with the skills needed to provide high-quality end-of-life care. The planned changes to employers' National Insurance contributions will further exacerbate these challenges unless additional funding is provided.

Despite these challenges, homecare has demonstrated its capacity to support people to die with dignity in their place of choice when properly resourced and integrated with healthcare services. The examples of good practice highlighted in this submission show what is possible when barriers are overcome.

We urge the Commission to recognise the central importance of homecare in end of life care provision and to recommend the systemic changes needed to strengthen its role, particularly in the areas of funding, workforce development, integration, and technological innovation.

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