

Social care: Independent report by Baroness Cavendish

How can we lock in the lessons of the crisis to build a more robust, sustainable, joined-up system of health and social care?

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Introduction: The Conversation About Social Care Is Too Narrow

Most conversations about social care start with funding. How much money is needed, and who will pay? The concern about money is entirely justified. But for years, this focus on money has meant that other big questions have gone largely unasked: what does a happy old age (or adulthood) look like? How can we keep people independent for longer? How can we build relationships and give people a life, not just reduce caring to a series of soulless, 15-minute tasks?

Looking around the world, there are signs that services which truly focus on how to keep people independent and connected for longer can improve wellbeing and ultimately reduce demand for social care. This gives hope that we can escape the cycle of inexorably rising costs and reinvest savings in the workforce.

At the moment, when the NHS is paid by activity and local authorities commission by the minute, the things that really matter – the outcomes for Mrs Jones – are missed. And false economies are made. Care workers are distressed by having too little time to care, and some of the best leave the service. Failing to properly rehabilitate people stores up health problems which could be avoided. Abandoning families without advice or information leaves them making poor decisions in moments of crisis and fails to build on the fact that families in this country are the backbone of the social care system.

We need to stop commissioning by time and task and start addressing the whole care continuum: from prevention, through medical intervention, rehabilitation, maintenance, and social care support. We know that social prescribing, for example, can vanquish type 2 diabetes. We know that people can improve their health outcomes if they become more active, at any age. We also know that isolation and loneliness are directly correlated with failing health. We have the tools to tackle all of these things – which will in turn enable people to remain independent for longer.

“Loneliness is one of the biggest reasons people end up in care homes. If you’re lonely, you don’t eat, you become frail; you fall” Care home investor

The pandemic exposed some longstanding problems in social care: a lack of integration with health; providers vulnerable to financial pressures; vacancies in social care and nursing; appalling job insecurity in social care and a virtual absence of GPs from care homes. It has also demonstrated a gulf in accountability between central and local government and the NHS, which needs urgently to be fixed.

But advances have also been made, in technology, in flexibility and in collaboration. While dentists retrained as respiratory nurses in the NHS, care workers stepped up to take on

tasks they had not been allowed to do before. Some care workers voluntarily left their own families to move into care homes; some hospital trusts set up mutual aid systems to share PPE with care homes. Unnecessary paperwork was jettisoned. In places where there was already collaboration between health and care, mutual respect has blossomed. At a conference of 400 NHS doctors and experts which I addressed in April, professionals said again and again that “we must never go back” to the old silos.

It is now vital to build on that spirit.

The big prize is to provide a more secure, fulfilling old age to every citizen, by putting humanity before bureaucracy.

Bridging The Divide Between the Public and Private Sectors

A major challenge, which we saw again in the crisis, is the hostility of many public sector actors to “business”. The social care system is bedevilled by a lack of trust, between public sector commissioners, regulators and the NHS, and largely private sector providers. This has injected significant and unnecessary costs into the system. It has led to burdensome and complex oversight, duplication, and rigid “time and task” commissioning which does not reflect the interests of users.

One outstanding rated homecare provider told us that her team spends around 20 minutes per week, for every single council-funded person they support, simply getting council social workers to sign off paperwork.

“Everybody feels they need to organise us, and not give care homes the credit for the achievements we have made in this crisis”. Staff nurse at large care home operator

Where pioneering commissioners have started to trust providers and worked jointly to reduce unnecessary bureaucracy and commission for outcomes, significantly better care has been provided at lower overall cost. This trend needs to be accelerated.

“When we started to trust our providers, we saved money”. Council Adult Social Care Director

The failure to understand business has another consequence: a surprising lack of interest in self-funders who do not rely on government help. About 45% of care home residents pay all their own costs. Overall, around a third of social care is paid for by consumers entirely from their own savings. Yet government has almost no data about this group, and there are few attempts to learn from what choices these consumers make. The CEO of one award winning domiciliary care provider with numerous outstanding ratings from Care Quality Commission (CQC) told me that he has never received a call from CQC seeking to learn from how his organisation has achieved this performance.

If the system is to work for all its customers, not just those funded by the state, there needs to be greater transparency and information. Care is a market, yet one in which the consumer is weak. Previous governments dismantled oversight and took little interest in self-funders. But the state can drive price transparency and provide better information, to help families make better choices.

The NHS and much of government still talk almost exclusively about care homes when they talk about social care. There is an urgent need for better understanding of the vital role played by domiciliary care, especially given that most people want to stay in their own homes.

One answer would be to let the NHS take over social care. On paper, this would join up the care continuum.

But that, in my view, would be a mistake. First, because the NHS is still struggling to join up primary and secondary care, let alone the whole continuum. Second, because the NHS is hierarchical, centralised and not person-centred. Social care is more innovative, more responsive, and human. Recent attempts to import a successful Dutch model of self-managing teams into the NHS have foundered, because the NHS culture cannot seem to cope with giving staff the autonomy required.

This review therefore proposes that commissioning remains with local authorities, but with a new regime of oversight, underpinned by a revolution in data. It also seeks to make the case that truly focussing on the individual – giving Mrs Jones a life not just getting her dressed– can have significant impact on both costs and wellbeing. Examples of impact in this review include the following:

- giving home care staff autonomy to provide the services they think clients need has improved patient satisfaction and reduced costs by 30%-40% in the Netherlands (see Chapter 2)
- commissioning for outcomes in the UK has reduced the size of some care packages by 50%, and enabled councils to raise staff wages (see Chapter 2)
- some types of supported living reduce burden: one study of Extra Care residents found that they improved their health over 5 years and averaged 3 fewer days in hospital each year than before they moved in (see Chapter 4)
- falls and fractures cost the NHS around £1 billion per year: yet there are cost-effective measures to reduce them which could be rolled out much more widely (see Chapter 5)
- installing acoustic monitoring in care homes can give staff back 40% of their time (see Chapter 5)

- issuing every citizen with an electronic health and care record would transform care and save hours of staff time

This Review

This internal review was commissioned by the Secretary of State for Health and Social Care in June 2020. The aim was to make recommendations for social care reform and integration with health in the wake of the COVID-19 pandemic, which could fit alongside the funding reforms planned by the Department in the context of the NHS Long Term Plan. It is intended to focus on the over-65s, not the whole of Adult Social Care, although some of its recommendations apply across adult social care (ASC).

My approach has been to look at systems while never losing focus on the citizen; the actual people we are trying to serve. For Mrs Jones – your grandmother and my grandmother – the reality of getting old and needing care is all too often a confusing, depressing journey: waiting around for hours to be seen by a bewildering array of different faces who never have enough time – whether that’s in the GP clinic, hospital ward, a step-down facility, or in her own home. Unless we keep a laser-eyed focus on Mrs Jones, what she needs and wants and what she is getting in Walsall compared to what Mr Smith is getting in Winchester, changes to architecture will never bring about the revolution that we all want to see.

“They are people first: part of a family, a community, not just defined by their age or disability but with potential. We need to look at what people can do, not what they can’t”
Rachel Shimmin, CEO, Buckinghamshire County Council.

Chapter 1: Locking in the Advances

The COVID-19 crisis has prompted a level of positive innovation, collaboration and flexibility which could be the foundation for a much more effective system going forward. We should seize this moment to build on those positive changes, remove any barriers to them continuing, and create a much more robust and integrated system.

1. Breaking the rules and empowering staff. In the NHS we saw staff rapidly retrain into different roles and perform well liberated from bureaucracy. Equally, many care workers stepped up to take on roles they had not done before, as District Nurses were called back into hospitals and GPs were largely absent. Delegated roles taken on by care staff have included giving insulin injections; wound care; taking blood pressure and temperature and reporting these back to GPs, and testing people for COVID-19, a procedure which is not straightforward, especially when dealing with people with dementia. Some even wrote death certificates. This suggests that care staff can take on more skilled tasks in future, and play an important role in improving health, not just managing decline. (see Chapter 3)
2. Technology. The dramatic switch to digital in the NHS also edged its way into social care. There was greater use of remote monitoring and video technology in care homes, enabling families to be more involved in their relatives' care and wellbeing. Many more providers also signed up to NHS mail, helping to connect a sector which is very fragmented. "This helped enormously in medicines management: it would be great if more communication and processes could go through this channel". Liz Whyte. It is vital that NHSX now completes this roll-out, and the Professional Record Standards Body continues its work on setting standards. Care staff will also need training in electronic record-keeping and GDPR, with adequate resourcing. (see Chapter 6).
3. Collaboration. The urgency of the crisis prompted some system actors to work more closely together and build greater mutual respect. Those who already had good joint working arrangements rose to the challenge much better than those which didn't.¹ Examples of positive collaboration include the Greater Manchester Opel system and mutual aid on PPE. For the first time, the NHS saw that social care was essential, especially to freeing up beds. This has led to cross-sectoral conversations which feel and sound much more like partnerships than they used to.

"Covid accelerated our working together. To support the shielded, it was important that people did not use information sharing as a barrier to working in people's best interests.

¹ CQC, ['Sharing insight, asking questions, encouraging collaboration: CQC publishes first insight document on COVID-19 pressures'](#), 2020

The proper sharing of details such as names and addresses when working was necessary to enable people to receive the essential support that they needed. People had to stop being excessively cautious about information sharing and more proactive in their proper use of people's information to achieve that outcome".

Cath Roff, Director, Adults and Health, Leeds City Council. (see Chapter 2)

4. Enabling Self-Reliance Through Direct Payments. During the pandemic it became apparent that many families were left in desperate situations without their usual carers. As a result, more flexibility was offered for spouses/partners/relatives to make use of direct payments; a very positive development which should be continued. The system should emulate Germany in giving all care recipients the option of receiving cash benefits for family members, whether through direct payments or Individual Service Funds. (see Chapter 2)
5. Public perceptions of residential care. Public perception of care homes through the crisis has probably accelerated future moves away from care homes and towards care at home. A [Policy Exchange/IPPR/Independent Age survey](#) found 31% of people saying they were now less likely to want to put their relative in a care home. For those over 65, 40% said they would be less likely to seek residential care for themselves. The Just Group found nearly three-quarters (73%) of people saying they do not want to go into a care home, the highest recorded level since the Group started asking the question in 2014. This figure rose to 82% among the over-75s, again the highest figure recorded. (see Chapter 4)
6. Public respect for care staff and carers. Amid the grief, the pandemic raised public consciousness about the valuable role of social care staff. Some even made the heroic decision to leave their own families and live among service users for weeks on end – a reflection of their dedication at a time when some GPs, for example, were reluctant to interact with patients. There is greater public awareness that care staff are not treated equitably to NHS staff, and that they deserve better. There is now an opportunity to tell a new story about care staff as people who work at the heart of the community, building networks and promoting independence, not just managing decline.
7. Greater awareness of care needs. Greater public awareness offers an opportunity for government to start the care conversation. A major barrier for the sector, until now, has been that people are extremely reluctant to think about their potential future care needs, let alone make concrete plans to pay for them. [One survey found nearly 4 in 5 \(78%\) of over-45s saying they had not thought about care, planned for it or spoken to family about it.](#) Among those aged-75+, 83% had not thought, planned, or spoken to family about care. One potentially difficult conversation is the possibility of moving in with children. Although one in 5 (21%) agreed they would like to live with children if they could not cope in their home, only one in 50 (2%) have actually had the

conversation about moving in. Many people leave care planning until it is too late and then – despite their intentions – children can end up picking up responsibility. One in 4 over-45s (25%) has had to help a parent, an in-law, or a partner to find residential care, rising to nearly one-third (30%) of married people. One in 6 (16%) has a friend who is having to do this. This means that a large and growing section of the population is encountering the reality of care: providing an opportunity to shape spending and saving patterns.

Chapter 2. Local v Central: Reforming Commissioning and Accountability

System reform, alongside funding reform, is fundamental to revolutionising the quality of care that people receive. But not for its own sake. Too much focus on the architecture can lose sight of whether things are actually improving for people on the ground. In Northern Ireland for example, integrated commissioning has not led to integrated provision.

What We Learned in The Pandemic

1. The pandemic demonstrated that DHSC had few levers over the NHS or local authorities. The emergency funding agreed by the Treasury did not all reach ASC as anticipated, despite some care home operators employing full-time staff solely to email and call local authorities. The abolition of the Audit Commission in 2010 has left an accountability gap which cannot properly be filled at the ballot box.
2. MHCLG was initially defensive, suspicious of private operators and with no comprehensive systems for tracking expenditure. The split of responsibilities between DHSC and MHCLG is a barrier to improving social care – especially in the absence of any formal oversight of local authority ASC commissioning, (beyond children’s services by Ofsted) since the abolition of the Audit Commission.
3. The NHS showed little comprehension of the care sector or its needs, beyond welcoming the simplification of discharge procedures. Linkages between NHSE and local authorities proved to be virtually non-existent.
4. The lack of parity between the NHS and social care became stark, even down to struggles over whether care workers were key workers.
5. Self-funders lack a voice. Money for social care comes from central government grant; council tax and social care precept, and self-funders – but public sector actors frequently ignore self-funders, despite the fact that they are actively making choices which could tell the state about what people value.
6. Most Clinical Commissioning Groups (CCGs) and local authorities procure, they don’t really commission, (if commissioning is defined as “the cycle of assessing the needs of

people in an area, designing and then achieving appropriate outcomes, delivered by the public, private or civil society sectors”).^{2 3}

7. Lack of trust between the public and private sectors imposes significant friction costs, ironically as a result of concern to control costs. Even small adjustments to care packages cannot be made without referrals up the line to social workers and contracts departments. CCGs and local authorities can end up micro-managing care delivery, rather than fostering the creation of flexible care plans co-produced between provider and citizen which would provide more responsive care and might actually save money.

There Is A Better Way: A New System of Commissioning and Oversight Is Needed

I am passionately convinced that there is a huge prize to be won if we transform the way we commission and regulate care services. This is the prize of a happier old age, care which is responsive to what people actually want, and which will ultimately reduce demand for social care, and hence the burden on both the health and care systems.

The evidence I have gathered suggests that it is perfectly possible to:

- improve user satisfaction and a higher quality service
- boost the morale of the care workforce by giving them more autonomy
- save money which can be ploughed back into care worker salaries

The key to doing this is to:

- commission for outcomes, rather than “time on task”
- build trust between commissioners and providers, enabling them to make significant financial savings in contracting arrangements and lifting burdensome bureaucracy from care workers, some of whom find the first thing they must do when they arrive at someone’s home is to pick up the phone to “clock in” with a suspicious employer
- enable care workers to look after the whole person, offering what they believe is needed, not what is dictated by a spreadsheet

² Cabinet Office, [‘Modernising Commissioning’](#), 2011

³ NACG ‘Medium Term Planning’, UKHCA 2020

“The focus on individual organisational outcomes is distracting from the needs of the wider system to work effectively for the people it serves.” [‘Beyond barriers’, CQC](#)

The Impact: Commissioning for Outcomes Can Raise Quality and Reduce Costs

The 6 examples which follow by no means represent the totality of pioneering commissioners around the world or in the UK: more work needs to be done to understand how many authorities are moving in this direction already.

1. Buurtzorg, the Netherlands

My conviction that we can provide much higher quality, person-centred care while also saving money and ploughing that back into staff wages stems partly from my extensive knowledge of Buurtzorg, a not-for-profit home care provider in the Netherlands.

Founded in 2007, Buurtzorg has been found to have the highest rates of patient/user satisfaction in the Netherlands.⁴ The consultancy EY⁵ has calculated that Buurtzorg also costs almost 40% less overall than competitor services.

Buurtzorg was created by a Dutch nurse who had become disillusioned with the way that the Dutch health service was failing patients and people in the community. “Healthcare and community care were defined as production...nursing, nursing care extra, guidance extra, for commissioners that’s the way they buy care, so many hours of this and so many hours of that”.⁶ One could describe the English social care system in very similar terms.

His answer was to give district nurses far greater control over patient care and allow them to operate in self-managing teams, each with a maximum of 12 district nurses and nursing assistants (the Dutch equivalent to HCAs or care assistants). Teams provide co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients.

The impact includes:

- each patients/user only ever sees 3 members of the team – they are not subject to the merry go round of strange faces which infects so much of English social care. They get to know all 3, and develop strong, trusting relationships. As a result, my interviews suggest, patients make fewer demands on both the health and social care systems

⁴ AARP, [‘Buurtzorg Nederland: Nurses Leading the Way!’](#), 2013

⁵ Ibid

⁶ Camilla Cavendish, ‘Extra Time: Ten Lessons for an Ageing World’, 2019, Harper Collins, pp 173-178

- patient self-management is central. The team provides intensive support at the start of the relationship, gradually withdrawing as self-management aids and equipment are sourced, and networks of friends, family and neighbours are created or strengthened. This has almost halved the hours of care needed⁷
- 24/7 access to the team has led to a decrease in unplanned care and hospital admissions
- its overhead costs are much lower than comparative organisations⁸
- all staff have iPads through which they communicate with relatives and update patient records in real time

In 2011, Buurtzorg employed nearly 4,000 district nurses and nurse assistants across 380 teams. By 2013, this had risen to 6,500 nurses in 580 teams.⁹ By 2016 it was caring for over 70,000 patients and the UK RCN reported that half of those had some form of dementia.

What is the read-across to the UK? While Buurtzorg is nursing-led, not all the staff have nursing qualifications and many of the interventions are those which would in the UK be provided by care assistants, some under the supervision of a district nurse. The RCN reports that: “Most of the nurses who join Buurtzorg are trained at a ‘generalist’ level (similar but not directly equivalent to a UK Registered Nurse in Adult Care). This allows them to deliver treatments from wound care and diabetes monitoring to IV infusion therapy and end-of-life care. Unlike in the UK, there is no formal district nursing qualification in the Netherlands and none of Buurtzorg’s nurses are trained to be independent nurse prescribers. Notably, the RCN’s visit to Buurtzorg in November 2015 did not observe many patients requiring ‘complex’ nursing care needs that would require the intervention of a Registered Nurse. The interventions which were observed were those more associated with Health Care Support Worker (HCSW) competencies, for example: washing, assisting with dressing, applying compression stockings, applying leg emollients, etc”.¹⁰

Buurtzorg is not the only provider of home care in the Netherlands. It operates in a competitive insurance-based marketplace where patients choose their provider. But Buurtzorg’s approach has enabled it to grow market share and tempt retired nurses out of

⁷ AARP, [‘Buurtzorg Nederland: Nurses Leading the Way!’](#), 2013

⁸ King’s Fund, [‘Buurtzorg Nederland presentation’](#), 2013

⁹ RCN, [‘The Buurtzorg Nederland \(home care provider\) Model’](#), 2016

¹⁰ Ibid

retirement to work for it. It is, in other words, an organisation which patients' value and staff want to work for.

The Buurtzorg model has been trialled in Scotland and England, with mixed results. The headquarters organisation of Buurtzorg believes the model has struggled, because the NHS is unable to cope with 2 key concepts: giving staff such a high level of autonomy and operating with low overhead.

I therefore believe this model should be driven out of Adult Social Care, primarily by local authorities and home care providers, working in partnership with the NHS where appropriate.

2. Gwynedd Council, NW Wales.

In Gwynedd, the Health Board became aware that many inefficiencies were created by not trusting providers. To adjust a care package by as little as 30 minutes required a social worker to go in and re-assess, then refer to a care broker, then back again. The board decided to let health and social care professionals in an area around 4 GP practices organise themselves to create support plans and adjust care packages within reason.

“Staff were really frustrated and tired, wanting to do the best for people but not really allowed”

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

Once working in this way, they have found that only half of the commissioned hours of care were actually needed. They have reduced the size of some care packages by as much as 50%, even in complex vulnerable cases. They have saved £275,000 annually on in-house provision. The model cost an additional £780,000 initially, because they increased hourly wage rates by £2 per hour, but due to the ongoing savings the council says that it is now able to pay those increased rates without increasing the overall budget. Gwynedd has uplifted care worker salaries by £2 per hour and offered each care worker a regular 8-hour shift made up of 6 hours direct contact, 1 hour travel, and 1 hour added value time. This extra hour is a significant innovation: it can be used to train, or go to a local GP meeting, or take Mrs Jones to a lunch club as she's shy, or pop back to see Mrs Smith as she was tearful this morning.

The council worked with Vanguard consulting to develop the model. To run the pilots, Vanguard says it charges a local council £19,000 per year.

In addition to cost savings, Gwynedd Council says that its model has also enabled it to reduce providers' administrative burden by decreasing the required data inputs from providers. The council has stopped asking providers for itemized billing, duplicate forms depending on funding sources, duplicate assessments, and care plans, late or missed calls, amount of time spent per call, and detailed notes in clients' files. All of the pilot sites that participated in this project reported improved patient outcomes, greater job satisfaction for staff, less time spent on bureaucracy, and closer collaboration between community resource team members.

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

3. Leeds Council

Leeds is aiming to go down the same route as Gwynedd, working with Vanguard and the National Development Team for Inclusion. A number of changes have already been made for example conversations with home care agencies have led the council to change its monthly monitoring forms which agencies found very time consuming. So far, the council has saved £1.4 million a year on avoided admissions to care homes, which it has ploughed back into the service.

"We felt dissatisfied with how we'd commissioned – the outcomes weren't what we wanted, we hoped to get a grip on quality. We want to commission for community wellbeing, not for home care. Now we start with strength- based conversations – what can they do for themselves, not what they can't". Cath Roff, Director, Adults and Health, Leeds City Council

4. Hertfordshire Council

Each person has an outcomes-based care plan, with outcomes based on the Care Act, rather than time and task. Under its "Connected Lives" model, the council asks all 31,000 staff working in ASC to think of the most innovative and appropriate ways to meet people's needs, "to make them as independent and happy as they can be". They incentivize care agencies to rehabilitate by replacing any hours saved on one user, with another package for another user. They can do this because they have a permanent waiting list. This might

not be the situation in more deprived areas: further thought needs to be given to how to incentivise private players in other regions to effectively rehabilitate people off their books.

“On Connected Lives, we worked to a simple logic that was if we could spend less on our care purchasing budgets and increase people’s satisfaction (both on an individual level and in the overall ASCOF satisfaction indicators) then that was the positive outcome we sought. Prior to COVID-19 (year 2019 to 2020), the department was underspent, even with difficult savings targets, and the outcome indicators were the best they had ever been and top quartile. In addition, staff were not satisfied in their work and we were able to inculcate a similar strengths-based model of working with our colleagues in the NHS, where it will inevitably save money too”.

Iain MacBeath, former DASS, Hertfordshire

5. Nottinghamshire County Council

Nottingham seems to be on a similar track.

“We are very good at measuring numbers – the numbers of people we see, how many people use the service, how much we spend – we have got to shift that so we are focusing on outcomes, so we can start to get a better idea of what the impact is, what difference we have made. The idea that “care” also being about the outcome of the care, is effectively our staff culture change and we are part-way into a 3-year journey.

Our Cultural work is twofold – strength-based approaches and staff owning and driving performance. The former we are just building the benefit card for this and there will be direct savings attached linked to this, which will include increased productivity for staff which is about less time spent in processes and administration and more time spent with people, less time undertaking formal assessment and more time on crisis support and decreased formal care package costs and increased investment in reablement/enablement, community development and prevention. Alongside this work we will be investing in community assets and employment services, so this is about a change in patterns of spend and better use of resources rather than cashable savings necessarily. The latter is about the workforce building a focus on results and outcomes so all that we do has purpose and impact for people, and this is a key enabler for all the work we are undertaking to manage increased demand, Covid pressures and further council savings.”

Melanie Brooks, Corporate Director, Adult Social Care and Health

6. CQC outstanding rated homecare provider

“Referring back in when the need changes takes up the time of the social work team. If someone is prescribed an antibiotic for 2 weeks, and you think they need an extra visit, you have to phone the Social Worker, they have to run it past their manager. Of the 30 people we support who are commissioned by the local authority, we spend about 8-10 hours a week speaking with the local authority to manage the needs. That’s out of about 400 hours a week”.

Homecare provider

7. Local Area Coordination

An approach developed in Australia, now being pursued in Thurrock and Derby City, this model is similar to the strength-based models above. It works by hiring a local area coordinator to work with older people. The aims are to co-produce a vision for a good life, recognise their strengths, build networks and take practical action. IPPR claims that this model offers “a social return on investment of £4 for every £1 investment”.

8. Cornerstone

Introducing a self-managing workforce at Cornerstone Scotland lead to more personalised and effective care which, in turn reduced spending on recruitment and the need for agency staff. Investing in technology and training upfront ultimately reduced overhead by 40%, which was reinvested back into pay and training.

What Drives Change?

If we want to replicate and spread some of these models, it is important to try to understand what sparks the change. In Germany and Japan, it has taken around a decade to fully embed new ways of commissioning. Some of the most radical decisions seem to have been taken by people who have experience in more than one sector and therefore understand the whole continuum. When hiring DAS’ into local authorities, for example, more attention could be paid to whether they have a health background. One senior local authority executive fondly remembered the old “Board Reviews” which brought experienced professionals from different sectors together. Bolstering CQC’s oversight function could be an opportunity to replicate CQC’s “experts by experience” inspection model: bringing different senior practitioners from different sectors together.

More work needs to be done here, but a [report by John Bolton](#) provides some insight:

“In Swindon and Manchester, the emphasis on outcome-based commissioning sitting alongside a strengths-based assessment model clearly has been led by the Directors. In Leeds the adult social care leadership has followed a direction over a number of years (at least a decade) and each leader has enhanced what the previous leader had already started with a strong focus on the community’s contribution to the solution. Leeds has a long history of community development with close links with social care. Whilst, Thurrock has developed a personalised model for social care that builds on their commitment to Local Area Co-ordination with the same Senior Team that has been together for 12 years. Finally, Somerset and Coventry have some of these features but an absolute message of promoting independence for their customers”. Professor John Bolton OBE, Oxford Brooke’s University (interviewed in his previous role as an associate of the Institute of Public Care)

It is important to note that in many of these models, upfront investment is made in technology and staff training, and sometimes even in pay – in order to recoup savings later on. Commissioners will need to understand this, if these models are to be successfully spread, and it is also vital that the systems are set up so that commissioners allow savings to be reinvested, rather than clawing them back.

What Are We Trying To Achieve?

Any effective system reform needs to achieve the following 4 aims:

- a. Better central grip: COVID-19 has highlighted how difficult it is for DHSC to get data and information about what local authorities and providers are doing, including whether funding earmarked for ASC is actually being spent on ASC. There are insufficient levers to drive best practice or tackle underperformance.
- b. Consumer power: This market is woefully underpowered, despite the fact that self-funders represent over a third of the market and pay 45% of care home fees We should empowering consumers to co- design care and drive the market.
- c. Keep people independent for longer and reduce demand for social care: We need to incentivise joined-up preventative care and encourage providers to improve wellbeing not just manage decline.
- d. A bigger voice for social care: The NHS has a long-term plan, national prominence and national advocates, ASC feels like the poor relation. Change should seek to put ASC on a more equal footing, particularly in joint arrangements.

We initially developed 5 possible models. These were:

1. Centralise and standardise. National price setting and assessment framework.
2. NHS Control. Local authority ASC functions integrated into the NHS; ICS commission for ASC without a formal local authority role.
3. Joint local authority and NHS ownership. ICS on a statutory footing with a formal role for local authorities on the ICS Board pooled budgets and commissioning.
4. Local authority Control of Commissioning. CCGs folded into local authorities, local authorities take responsibility for both health and ASC commissioning.
5. Earned Autonomy for local authorities. Space for local authority innovation. The best local authorities bid to take greater share of commissioning budgets; the worst taken over by independent trusts.

DHSC has the full pack, together with summaries of the international analysis which informed this work.

These were whittled down to 2:

Model A. Integration of health and social care commissioning through ICSs.

Model B. Continued local authority commissioning, but with greater transparency on spending, earned autonomy for the best performing local authorities and intervention in the weakest.

In further developing those models we paid particular attention to:

- what elements of adult social care are better decided at the national vs local/system level?
- how to better empower users of social care (including both state and self-funders)?
- the role of CQC
- how to increase transparency about spending and outcomes to drive improvement?

Model A: Joint ICS Commissioning

This model would see health and adult social care budgets pooled with Integrated Care Systems bringing together local authorities and the NHS to commission health and care services. Needs assessment would be conducted at the ICS level.

Local authorities would not have discretion over how much funding to contribute to ASC but would have influence over spending. Governance would have to be constituted to give local authorities meaningful influence, this could include equal representation on the board or making the ICS accountable to local authority scrutiny committees.

ICS boundaries would need to be contiguous with local authorities (and will in any scenario). Those ICSs which cover a larger geographical footprint (i.e. West Yorkshire) will choose whether to delegate commissioning decisions to place-based units.

ICSs would be required to use a commissioning framework that focuses on outcomes for their population and which encourages collaboration/join up. To stop local monopolies developing, we would suggest clear metrics be published at ICS level on performance: for example cancer survival rates, elective surgery waits.

Does this model meet our objectives?

Better Central Grip: Yes

Consumer Power: Yes (if outcomes focused)

More Independence, Reduced Demand: Yes

Bigger Voice for Social Care: No

Scale of Change: High

Political Challenge: Medium

Model B: Earned autonomy and intervention for local authorities

Here, local authorities would retain responsibility for commissioning but would be required to develop and use a commissioning framework that focuses on outcomes and prevention, rather than time on task. The extent to which they do so would be inspected by CQC.

Local authority social workers would continue to conduct needs assessments as now, preferably in partnership with the NHS.

There would be the opportunity for high performing local authorities to grow their commissioning remit: some local authorities have for instance already persuaded CCGs to delegate a share of their commissioning budgets to them. This model would introduce a formal 'right to request' a greater share of those budgets for high performing local authorities.

Co-operation with ICSs or other place-based NHS systems would be encouraged, but not mandated, as a means to delivering joined up, preventative care.

On the flip side there would be the power for DHSC to intervene in the worst performing local authorities. This would be underpinned by a new inspection regime at the local authority commissioning level and standardised data collection/reporting.

Alongside this, DHSC could also introduce a requirement that a fixed proportion of ASC funding must flow directly to providers.

Does this meet our objectives?

Better Central Grip: Yes

Consumer Power: Yes

More Independence, Reduced Demand: Yes

Bigger Voice for Social Care: Yes

Scale of Change: Medium

Political Challenge: Low

Recommendation

Both models would be a significant improvement on current accountability system and go a long way towards meeting the objectives outlined in Para 5. However, our recommendation is to adopt Model B – earned autonomy and intervention for local authorities.

The NHS is still struggling to join up primary and secondary care, and to understand social care. So although Model A offers the promise of joined up health and social care commissioning, joint commissioning may not be in of itself the answer. Further, the experience of Northern Ireland suggests that integrated commissioning does not necessarily result in integrated provision. Rather than introducing ASC into ICSs now, it

would be better to allow them to continue integrating health care services and to revisit the role of ASC in the future, once they are more of a known quantity.

What's more it is likely, given the heft of acute trusts, greater resources and national profile of the NHS that regardless of the governance mechanisms put in place, the NHS and acute trusts will dominate discussions and decision making within the ICS. This could effectively lead to an NHS takeover of ASC by the backdoor, with the concomitant danger that the transactional, less person-centred approach of the NHS moves into social care, further weakening reablement (see Chapter 5).

It would also be very difficult, simply as a result of their scope, to intervene in ICSs that weren't commissioning well. They are already local monopolies and there is a real risk they become 'too big to fail'. CQC suggested to us that every NHS and care provider in a failing ICS could be taken into special measures: but that does not seem practicable.

Health and Care Integration should still be encouraged within Model B, although as a route to better user outcomes rather than an end in of itself. What's more, by not imposing a national one size fits all model of integration, local partners would have greater flexibility to innovate and find out 'what works'.

Model B has the potential to take the best elements of local authority commissioning – which is population based, close to users, has freedom to innovate, and can spread best practice. However, these would sit alongside much tighter national control, price regulation and new expectations on commissioning for outcomes. Taken together, centralising these elements could begin to raise quality and improve trust across all levels of the social care system.

Model B has the ultimate fall back that underperforming commissioners can be taken over. And we know from other areas of public policy, even the threat of intervention often drives performance up in sectors. It doesn't rule out moving to a more integrated model in the future.

Regulation, inspection, and improvement

Central to any of these models is ensuring that there is sufficient accountability for commissioning, transparency to empower consumers, and support to help the sector improve.

The [2016 CMA report](#) suggested that these functions should be the responsibility of a new independent body which would:

- hold commissioners to account

- share best practice and analysis
- advise the government on the cost of adult social care and promoting transparency in fee differentials

We do not believe that one body is capable of doing all of these functions. The experience in education and policing shows that regulators that also lead improvement work leads to a situation where inspectorates are ‘marking their own homework’. Ofsted for instance was heavily criticised for running ‘improvement seminars’ led by serving HMIs, and then those same HMIs inspecting the same providers that had attended the seminars.

We propose instead that CQC builds on its system level reviews to take formal responsibility for inspecting commissioning. Alongside it, an independent price regulator ‘Ofcare’ could be established or sit within DH and a new ‘National Academy for Social Care’ could drive digitisation and support improvement in adult social care.

CQC is ten years old: time for a reset

When it was created, CQC was emphatically on the side of the consumer. It needs to regain that clarity. It should also focus on regulation and perhaps not stray too much into NAO-style reviews. It should be ruthlessly focused on outcomes and not, for instance, be overly concerned about the mechanics of integration.

For that reason, CQC should continue to assess provider performance on the basis of the quality of care they provide, rather than CQC’s proposals to rate individual institutions on their contribution to the system. Integration is largely beyond their control and is of little interest to users who want to know where they will receive the best care for them as individuals.

Nevertheless, the abolition of the Audit Commission has clearly left a gap. While Ofsted inspects schools and children’s services, there is no central oversight of how local authorities commission ASC. We propose that new commissioner level inspections be introduced at the local authority or ICS level. These will look at:

- local authority commissioning practice – What outcomes are they delivering for their population? What does the quality of care look like for an elderly person in Calderdale versus Brighton?
- how are commissioners shaping the market and driving out poor providers? (to help avoid the formation of local monopolies)

- ‘case journeys’ (as per Ofsted inspections) – with a framework for what a good health and care journey looks like from the user’s point of view – including personalised and co-designed care
- self-funders: This would include self-funders and the extent to which commissioners are meeting their requirements to them

We would suggest that CQC reports on commissioning would not be graded, but instead would be narrative reports, as per Ofsted SEND inspections. The exception would be in the case of the worst performing local authorities where the CQC, based on a set of clear criteria, could make the recommendation of ‘place in special measures’ which would trigger intervention.

We would also propose that CQC sheds its market oversight function. Several local authorities have told us they commission their own oversight work as CQC’s data is not comprehensive. We would suggest that DHSC takes on this role, perhaps using Companies House data.

Intervention

If Model B is adopted, those local authorities which are deemed to be ‘requiring special measures’ would see their commissioning responsibilities taken over by a nationally imposed and constituted trust. This is what currently happens with Local Authority Children’s Services.

We do not believe that intervention would be required in many cases. By intervening in the worst ~10 local authorities, the threat of intervention would also help to drive out poor practice among the rest.

Intervention is much harder in the ICS model, not least because of the significant capacity issues involved in trying to take over an entire health and care system, and because of the span of ICSs activity it is unlikely all of the areas would be performing poorly, making intervention a crude tool. We do not believe that CQC’s suggestion of putting every provider within a ‘special measures’ system into special measures themselves is workable or desirable.

Price regulation

In both Japan and Germany, national price regulation helps to ensure long term stability of the social care market and gives national government’s greater market shaping powers.

The CMA 2016 report recommended the creation of a price regulator for social care. This would serve 2 functions:

- publishing an expected ‘floor’ price for different levels of state funded care (and acting against individual examples of egregiously high fees)
- introducing greater transparency about costs to help self-funders

The first of these would help to give social care providers better certainty and stability. Providers tell us that one of the biggest barriers to long term planning and investment is uncertainty about pricing and a ‘race to the bottom’ in terms of fees for state funders – this also exacerbates the problem of ‘care deserts’ in areas with large numbers of state funded as opposed to self-funded users.

Pricing control could also allow national government to better shape the market to focus on reablement and independence. In Japan for instance use of price regulation has enabled the government to incentivise a shift away from care homes and towards care at home.

Greater transparency around the cost of care would better enable self-funders in planning for and deciding on their care. However, as per the CMA report we do not recommend that, at present, the price regulator should try imposing parity between state and self-funded fees as that is clearly beyond the scope of the current, and any proposed, funding envelopes.

An HQ for social care

Social care lacks an HQ, a voice, and the kind of architecture which is provided in the NHS by the royal colleges, NHS providers and NHS Confed. It also lacks a strong national improvement agency.

COVID-19 has demonstrated the huge opportunity for “zoom medicine” and digitisation. It has also shown that the care sector urgently needs upgraded software and digital skills, if it is to help provide integrated care.

We propose that a new learning and improvement agency, ‘National Academy for Social Care’ be established to fill these gaps. It would fulfil 3 roles:

- it would help to spread good practice and help local authorities to commission for outcomes, something which may require upfront investment to achieve future savings
- it would create networks of employers, providing a similar forum to NHS Providers/Confed and filling the gap in support for those providers who are 'poor to average' but not inadequate, to help them improve
- it would turbo-charge digital transformation by engaging in a time limited, programme to drive digital uptake, training in electronic record keeping and information governance and transformation across the sector. This could be part-funded by the sector and could involve offering grants to procure new hardware/software for smaller providers. It could also create a digital skills passport to reduce the frustration of staff who have to start again every time they switch employers

One way the Secretary of State can turbo charge digitalisation and consumer power would be to announce that every citizen will have an electronic health and care record within 2 years, accessible to everyone that cares for them. One way to drive uptake could be modelled on Obama's system of bonus payments to doctors and hospitals which produced electronic records (as part of the fiscal stimulus package). The National Academy for Social Care would set common digital standards, to allow for passporting/compatibility, but individual actors/systems could procure the systems that work for them

The Academy would not be a royal college but should be a provider-led body, chaired by a domiciliary care provider, to ensure that it is fully grounded in the real needs of the sector. This would be more credible with the sector; it would give providers a greater stake in shaping the organisation and driving the future of care provision. More pertinently, it is providers who best know what their improvement needs are. A DHSC controlled body on the other hand, might lack the same level of insight, or credibility with the sector, although it would avoid problems of producer capture, and the risk of becoming a vehicle for vested interests to act as a barrier to reform.

One way to square this could be to ensure that governance of the Academy is genuinely constituted by a range of providers with tight accountability to DHSC on spending.

A secondary effect of creating this Academy should be to raise the national profile of social care in comparison with the NHS. It could also potentially host the register of care staff (see Chapter 3).

Empowering consumers

The care market is unusual in that consumers do not drive change. Care should be co-produced, but that happens too rarely. And there is too little information to guide consumer choices.

To empower users, we propose:

1. Promoting personal budgets and direct payments: Building on the requirements of the Care Act on local authorities to inform users about personal budgets. That could involve a national campaign on personal budgets, direct payments and Individual Service Funds, working with local partners or using CQC to assess the steps that local authorities are taking to promote personal budgets and to share best practice. Some interviewees have suggested to us that direct payments should be made much simpler to access; we suggest that further work be done to explore this.
2. Providing greater flexibility over who can take the direct payments. These cannot usually be used to pay a spouse, partner, civil partner or a close relative living in the same household, unless the local authority agrees it is necessary to meet care needs or to provide administrative and management support to enable someone to use the payment. However, Germany is experimenting with paying direct to spouses; we would urge DHSC to build on the greater flexibility in the crisis to widen eligibility.
3. Potentially, create new entitlements to make the Care Act real: One senior local authority executive suggested to us that a further approach to realising the Care Act and making it more intelligible to the public, could be to build a "person first" offer that sits alongside the national outcomes framework and sets expectations of commissioners. This could include a relatively detailed version for the state and simpler version for the public. It could look something like the following 'wherever you live you can expect the following for example, 1 joint package, not 1 hospital package and 1 care package. When you go to hospital you will get for example. 6 weeks free reablement, we will work with you to get you back on your feet and draw up a care and support plan with you and your family based on what you can do, not what you can't.'
4. Better advice: In Japan, social workers play more of a 'guiding' role as care managers, helping people to choose the care that works for them. In the UK, this is a gap which needs to be filled. In the longer term we should look to provide other impartial sources of information to support users in their care choices. One option could be to develop something akin to 'Trip Advisor' for social care and/or a friends and family survey, akin to the Friends and Family Test in the NHS.

Chapter 3. Building one united workforce

We need a united workforce across health and care, to underpin a health and care system whose budget should be increasingly committed to prevention, to reablement, and to “giving people a life” as Professor Martin Green of Care England has said: not simply meeting their immediate care needs.¹¹

A united workforce is not the same thing as one single workforce. While conceptually attractive, one workforce - or a National Care Service - would be dominated by the NHS, which still struggles to provide responsive, human services based on outcomes beyond the medical. The continuing cultural gulf between health and social care was demonstrated by the recent creation of an [NHS People Plan](#) which mentioned social workers in the NHS, but not care workers in social care. The culture of the NHS is still largely one of “doing to” patients, and the NHS has much to learn from social care about how to be responsive and human facing.

Health is fundamentally the responsibility of the individual, with lifestyles having a large impact on preventing ill health, and we know that the most successful rehabilitation (see Chapter 5) is that which co-opts and supports people into driving their own recovery. We need more social and less medical models of care if we are to keep people independent for longer.

A united workforce is one with a common language, common training standards, pay parity for similar roles and experience, and parity of access to training and professional development.

Many of the same old challenges remain: to reduce attrition in social care, raise the status of the workforce, and make caring feel like a career. But I also believe that our objective should now be wider: to ensure that an ageing population has access to high quality care which helps individuals remain independent and in their own homes for as long as possible, reducing pressure on the NHS. That means not just giving people a pill, or helping them to get dressed, but tackling loneliness and isolation, creating networks, driven by properly measured co-produced outcomes.

For too long, the social care workforce has been seen as a last resort to manage decline. I believe we should be much more ambitious, seeing it as an innovative, person-centred cadre who do not simply carry out “basic” tasks but also build stronger relationships with individuals, family and neighbour networks which improve outcomes. This would, in turn, raise the job satisfaction, respect and status of the workforce and in some cases, pay – on

¹¹ House of Commons, Health and Social Care and Housing, Communities and Local Government Committees, [‘Long-term funding of adult social care’](#), 2018

the basis that this workforce is increasingly taking on delegated tasks from NHS staff, and freeing up their time.

Unfortunately, the instinct of the system is to believe that only the NHS can provide quality. Enhanced Care in Care Homes is an example of where the system assumed that better care must mean more clinical support – when it could have been seen as an opportunity to train up care staff to take on more roles.

In the pandemic, we saw that many care workers are dedicated, and highly capable of doing more skilled tasks. The public saw that too. Those advances must now be built on.

The Way We Care Is A False Economy

The literature about recruitment and training does not always fully reflect the intense frustration and bureaucracy that care worker's experience. These include:

- Frequent churn within the sector. Care workers may sign up to work for one employer, only to find that their contracts have been awarded to another agency. “I was Taped-in from my old job with 2 other organisations. No one knew anyone anymore, it just felt it wasn't person-centred, the brokerage process was just an excel spreadsheet of people bidding with no idea of the care that was needed. It became red tape, not people”
- Having to retrain. Many employers do not trust training done by competitors, so ask staff to retrain. This can be demoralising. “They don't appreciate I've got years of experience. I felt it was back to the beginning each time”
- Not feeling trusted. “Before I even say hello, I have to get on the phone to prove I was there and start the clock ticking. It's not fair”
- Not being able to look after the whole person. “I can't bear not to be able to give them the care I know they need. Some of our clients see too many faces...it upsets them”. It was this kind of sentiment which led to the foundation of Buurtzorg (see Chapter 2) and the philosophy of self-managing teams, pioneered by Helen Sanderson
- Lack of job security. A quarter of care staff are still employed on zero hours contracts, rising to 40% in the domiciliary care workforce.¹² While some workers are happy with these, fitting shifts around their lives, most are not

¹² Skills for Care, [‘The state of the adult social care sector and workforce in England’](#), 2019

- Not being paid for time spent travelling between visits. DHSC needs to consider its role here in relation to the [recent tribunal ruling against Haringey Council](#)
- Not being able to build relationships. “After I left [the agency], I had to un-learn ...”
- Worst of all, years of experience are worth almost nothing in terms of pay. The introduction of NLW has actually reduced the pay gradient: the pay difference between care workers with less than one year of experience and those with more than 20 years of experience is now £0.15 an hour.¹³ It is vital that we find ways to ensure that pay rises with skills and experience. In an era of financial constraint this should be the priority, over raising the base wage

Many of these problems stem from 3 decades of standardisation and specialisation, treating social care as a product that can be separated into different activities parcelled out as cheaply as possible. Subdividing care in this way has created enormous complexity and unintended consequences. It has left many recipients of care with no continuity, seeing sometimes 80 different faces in a year, never building a trusted relationship. It has removed the autonomy of care workers and turned them into automatons, assigned to do specific pre-determined tasks. It has led to pressure on providers to pursue economies of scale, as complex contracting processes struggle to interface with small providers.

The result has been plummeting morale among both care workers and their clients. A care worker who has to deliver only the pre-assigned, paid-for task cannot afford to bother about prevention, or even sometimes to act on deterioration in a person’s condition.

“Healthcare and community care were defined as production...so many hours of this and so many hours of that. [The relationship between nurses and patients became] extremely disturbing”. Founder, home-care organisation.

“The processes of registration, intake, planning and supply were divided up and performed by different people. The idea was this would lead to efficiencies, the top focus of managers being care-cost per hour. But it wasn’t working”. John Seddon, Vanguard Consulting

As argued in Chapter 2, the best way to improve workforce morale is to commission for outcomes and give staff more autonomy. However, there are other factors which also need addressing.

Recruitment. The care sector went into COVID-19 with substantial vacancies and significant sums being spent on agency staff, facing stiff competition for staff from hospitality, leisure and catering. COVID-19 has changed the picture: employers report that they are hiring the newly unemployed from these sectors where there is a huge amount of

¹³ The King’s Fund, [‘Average pay for care workers: is it a supermarket sweep?’](#), 2019

talent and a customer focus. So, recruitment is no longer a major issue, though there are still some worries about a falling flow of EU labour due to Brexit.

Nevertheless, it is still important to focus on retention. Providers interviewed for this review report that the first 6 months are usually crucial in keeping people for the long-term. Getting the right training, feeling valued and being able to make caring a career is vital.

Training. In 2013, in the [Cavendish Review](#), I recommended the creation of the Care Certificate to improve training and observed practice, to improve employer confidence and reduce duplication, and to build a common language and understanding across health and social care. This was partly as a result of the interviews I had done with registered nurses, HCAs and care workers who felt unsure about what tasks could be delegated and taken over because of the lack of a guiding code of conduct. I had hoped that health and care staff would be trained together, to improve understanding. Where this is happening, employers report that it does indeed bolster a sense of respect and enhance cooperation. The new Health and Care Academies should be encouraged to train staff together wherever possible.

Training is still delivered by a raft of different training providers in an unregulated market which means that where someone trains is still more important than the qualification they receive: a “Barchester” or “Home Instead” - acquired Care Certificate is often of more value in the sector, for example, than one acquired from a smaller business. As a result, staff do not always receive recognised, transferable skills; and there continues to be duplication.

As the sector slowly becomes digitised, the Care App offers the potential to provide staff with digital skills passports for their qualifications, to avoid having to retrain each time they move. This should apply not only to care but right across the health and care system, so that staff can rotate more easily into different positions for which they are qualified, while staying in their local area. Leeds Academy, for example, has developed rotational programmes in which OTs go into council rehabilitation or to the acute trust, without going through a whole assessment process from scratch.

The 21st century social care workforce needs training in 4 broad areas:

1. Training to support activities of daily living.
2. Training for clinical support and delegated clinical tasks.
3. Training in digital skills.
4. Training in building relationships – this may involve “unlearning”.

“There is a need for training for home carers around conversations and relationships. People have been taught to not apply the skills they have. The old message to providers was get to a patient’s address by 7:30 and leave by 8 so no time for chit chat or do anything extra and if want to do extra you need to ask permission for each little thing. Because this was how people were trained in the past, they need to relearn and be retrained to have the goal to get to know their patients” Meilys Heulfryn Smith, Programme Lead – Community Transformation, Gwynedd Community Health and Social Care Transformation Team

Making this 4-part training a reality is not easy, not least because of barriers to funding. (1) Is already mandatory for all care staff. (3) needs initial funding from the DHSC, as I argue in Chapter 6. (4) Will follow only once commissioners change course, although the proposed National Academy for Social Care should also provide support. (2) – upskilling care workers to provide more clinical tasks – is already happening through Community Health Services (see Chapter 5). What is needed now is to extend that training to staff employed by independent providers, through the Better Care Fund (see below).

Bridging the Divides Between the NHS and Social Care

The NHS and social care employers recruit from the same pool of people but the NHS’ more generous terms and conditions mean that the NHS is usually the employer of choice. Around 16% of staff move from social care into the NHS; only 5% move the other way. The gap exists even within nursing: there is a 7% gap between the pay rates for adult social care nurses, and the rates available for nurses in the NHS.¹⁴

Rather than rail against this we should perhaps accept it and work towards a more explicit, shared investment approach between the sectors. Considerable amounts of money and effort go into poaching good staff from one sector to another: it would be much better if the NHS were to invest instead in helping to upskill parts of the care workforce which will benefit the NHS. We know that the NHS is struggling to provide nurses into social care. Registered nurses in adult social care declined by 30%, from 51,000 in 2012 to 2013 to 15,000 2019 to 2020.¹⁵ While some of this will be accounted for by the creation of some Nursing Associate roles¹⁶, it is equally likely that these shortages are adding to the burden on social care, and this should be recognised by CCGs.

Nursing tasks which are increasingly being taken on by care staff include insulin injections; wound care; podiatry, taking blood pressure and blood sugar and reporting these back to GPs, and testing people for COVID-19, a procedure which is not straightforward,

¹⁴ The Health Foundation, [‘The real cost of a fair adult social care system’](#), 2019

¹⁵ Skills for Care, [‘The state of the adult social care sector and workforce in England’](#), 2021

¹⁶ The Health Foundation, [‘Health and social care workforce: priorities for the next government’](#), 2019

especially when dealing with people with dementia. We have been told that some staff have also had to write death certificates during the pandemic. This suggests that care staff can take on more skilled tasks in future, and play an important role in improving health, not just managing decline. Several care providers have identified the need for clinical training in other areas such as tracheostomy management. Many independent providers say they cannot access funding for training and not all are commissioned to carry out these tasks, but if they were, this could be one way to raise the wages of care staff in relation to experience.

The excellent mapping exercise carried out by DHSC colleagues for this review, of key roles in the health and social care sectors (see Appendix), demonstrates a very strong overlap between many of the tasks and responsibilities. It suggests that social care is not less skilled; and that care workers often have to demonstrate more independence and maturity than health workers who are more likely to be working under supervision. For a junior care worker versus a Band 2 healthcare assistant, the authorised tasks are almost identical, but the care worker will need the maturity to function even more on their own.

Similar roles should attract similar levels of pay – even if NHS staff receive better benefits. Funding should reflect the value of care work to the NHS bottom line: reducing hospital admissions or undertaking delegated tasks.

One area where this already happens is in some public-sector provided CHS reablement services. In the most integrated localities, council-employed care staff routinely receive instruction from OTs, physios and community nurses, operating to shared standard operating procedures. There remains a gulf, though, between the NHS and independent care providers.

One way to overcome this would be to require common competencies at a national level, between senior care workers and NHS workers on Agenda for Change band 3. At the moment, a typical senior care worker's qualification can include a Level 3 Diploma in Health and Social Care, a Level 4 Diploma in Health and Social Care Management or an Advanced (Level 3) apprenticeship. A Band 3 HCA might have a Level 3 Diploma in Healthcare Support, or an Advanced (Level 3) apprenticeship.

“The care certificate and NHS band 3 recruitment and training have been divorced from each other and yet the core tasks for each group of workers are very similar”. Ex-DAS, local authority.

Requiring common competencies would necessitate a review of remuneration, which would generally lead to an uplift for non-NHS workers, including even many of those employed on higher salaries by councils.

Given the financial constraints it would therefore be imperative for some of the money to come from NHS/CCG budgets via the BCF. This could be done by making it part of the statutory minimum contribution to social care.

Employers would need to be properly consulted on this proposal: not least since the reality is that 20,300 providers create their own job titles and structures. Consideration should also be given to helping private employers with insurance costs which increase when taking on clinical tasks.

A Joint Role? Lessons from Denmark

If such common competences were to be developed, this would lay the foundation for eventually achieving a new joint role across health and social care. In the early 1990s, Denmark created 2 such joint roles: The Social and Health Care Assistant and the Social and Health Care Helper. The aim was to consolidate a number of roles, create a clearer education and career ladder, and further formalize care work. The 2 new roles replaced 4 old ones: Home Care Assistant, Nursing Assistant, Assistant in Psychiatry and Nursing Home Assistant.

The new training was intended to allow individuals to work in a number of different settings with different patient populations. Danish students acquire knowledge in broad competence areas including practical and personal help, personal care nursing tasks, health promotion and prevention activities, coordination, supervision and instruction, and activity and rehabilitation. The Assistant role includes medication administration and drug dispensing, wound care, blood pressure and blood sugar measurement, rehabilitation, building independence, observing and record symptoms, acting as a link with hospital and doctors, helping patients with the activities of daily living, and supervising Social and Health helpers.

Creating a joint role at Band 3 across the NHS and social care could become a lynchpin for greater mutual understanding, and making experience pay.

Career Progression

Beyond creating such a senior care worker role, one of the most obvious ways to improve the sense that caring is a career would be to facilitate progression from such roles into (i) Registered Manager roles and (ii) Band 4 Nursing Associates.

(i) CQC research has found that Registered Managers are a vital for assuring quality. Skills for Care runs a membership scheme for RMs which charges fees; it would be worth looking at whether it would be possible to build on this scheme to identify the best RMs and provide them with leadership development programmes. This could be modelled on

Firstline, the network for Consultant Social Workers run by Frontline, which some CSWs credit with having kept them in post.

(ii) The role of Nursing Associates is increasingly vital one, to build the pipeline of future registered nurses in both health and care. The alarming collapse in the numbers of district and community nurses in recent years (see Chapter 5) means that training more social care Nursing Associates could reduce burden on social care nurses, and free up more of their time to focus on more complex tasks.

However, there are very few Nursing Associates in social care compared to the NHS, and even in the NHS, progress is too slow. HEE has a target of 7,500 Nursing Associate apprentices entering training in 2019 to 2020 but it is quite clear that the requirement to pass an NMC-approved Foundation degree a barrier to increasing recruitment through FE Colleges. Government is working with PHE and others to improve numbers within the NHS, however it should be of equal concern to DHSC that there are so few nursing associates in social care – and that we do not even have accurate data about the numbers.

Work undertaken by DHSC suggests that there were only around 500 Nursing Associate apprentices in the social care system across the most recent wave which ran from January 2019 to March 2020. During the same period there were an estimated 2,900 nursing associate starts in NHS provider settings.

There are 2 main problems. First, the Foundation degree requirements are too onerous. Second, the Apprenticeship Levy is not working as it should be in social care. In theory it is possible to transfer unused funds from larger, levy paying organisations to smaller non-levy paying organisations: but this is not happening enough in practice. Only 18 out of 40 training providers hold contracts with the Education and Skills Funding Agency (ESFA) to deliver apprenticeships to non-levy-paying employers. Some employers do not like the fact that they cannot tailor the training to their specific needs. Others say that it is hard to pool levy payments locally. More work is needed to unlock Levy funds for the sector.

Health and Care Academies

Something very positive is happening, almost under the radar: the creation of health and care academies around the country. Although most are very new, they seem to be largely the product of closer on-the-ground partnerships between the NHS and local authorities. The Leeds Health and Care Academy, for example, which I have interviewed, has 9 staff, funded by big anchor institutions: Leeds City Council, the Acute Trust, and Leeds University. There is also a strong health and wellbeing board.

The vision for Leeds Academy sprang from the combined challenges of staff shortages in health and care, and the economic development imperatives of a growing digital sector next door to areas of deprivation and youth with low skills. This led to a desire to “grow our own”.

“Good jobs are integral to good mental and physical health and therefore ensuring citizens are in good employment will reduce demand on health and care services.”

Sara Munro, Health and Care Academy, Leeds

Crucial to the venture is that LTHT has agreed that instead of continuing to develop its own nursing pipeline, the Academy will develop the health and care workforce. This paves the way potentially for joint roles of the kind I have described.

Employer-Led Initiatives

A sector-led Care Academy

Employers know best what is needed and what is possible. It is vital that they consulted upfront on these proposals and are in the driving seat as far as possible. One leading domiciliary care provider is currently in the process of establishing its own Care Academy, working with a major training provider. Although progress has been slowed by COVID-19, the aim would be to work with universities/colleges to build new qualifications and attract more talent into the sector. I have discussed with this provider whether they might be prepared to involve other employers in this initiative and the answer is yes, so long as the initiative remained under employer control. I think this is worth exploring further: a properly sector-led initiative, rather than one led by a quango, does have merit.

The Teaching/Research Care Home

Lack of understanding between health and social care is exacerbated by the lack of exposure that medical students and doctors have to social care. Even social work students tend to have placements in children’s care homes, learning disability or mental health, not older people’s care homes. Yet a placement in a care home or domiciliary care offers the opportunity to learn about people with complex health needs. If framed properly, it is also a way for staff to get direct mentoring from residents.

Teaching/research-based care homes were first developed in the US in response to scandals about care, and the shortage of trained geriatric healthcare staff. Models have also been developed in Australia, Norway, The Netherlands and Canada.¹⁷ Evidence

¹⁷ Edinburgh University, [‘The vision for a teaching research based care home’](#)

suggests that they not only aid teaching and learning but can help to reduce unnecessary hospital admissions, improve staff competencies and make staff more enthusiastic about working in care homes.

With a bit more imagination, it would be possible to enlist residents to become teachers. We know that turning recipients into agents of their own care: something which improves health outcomes, as argued so powerfully by Atul Gawande in “Being Mortal”. Such experiments should be eligible for funding from the proposed National Academy for Social Care, once the pandemic has abated – building on the DHSC pilot with Care England and asking the major domiciliary care chains to participate.

Developing A National Care Workforce Strategy

While Academies and some far-sighted commissioners are building a more united workforce from the ground-up, this is very ad hoc. There needs to be a national strategy for the care workforce which sits alongside the NHS People Plan. This would identify and quantify population health and care needs over time, determine what skills and competencies are needed, and work towards joining up training and professional development.

Looked at in the round, it is clear that an ageing population is going to need a different skill mix to now. There will be increased demand for geriatricians, community and district nurses. Yet those are exactly the areas where there are the greatest shortages. We need the right staff to support the policies advocated in this report; and if those policies are successful, they in turn will change the skill mix needed. One study of Extra Care Housing, for example, finds that residents are making fewer visits to GPs, but increasing visits to Practice Nurses (see Chapter 4). Nursing, and primary care is going to bear an increasing load from the emphasis on prevention, rehabilitation, and the management of chronic disease.

Given that HEE already works with the unregulated HCA workforce, and has a role in considering the number of nurses required in social care, it would make sense for it to have responsibility for the care workforce too. There are concerns that HEE is already under pressure from COVID-19 and filling nursing shortages, and that it lacks the appropriate policy expertise. In both 2017 and 2019, HEE failed to produce strategies which properly reflected the needs of the social care workforce. However, its new leadership is much better grounded in social care. There is also the challenge of needing primary legislation to expand HEE’s remit. However, it seems to me imperative that the care workforce strategy sits with the overview of the wider nursing market. Skills for Care, for example, sits too far from the NHS.

An alternative would be to ask employers to take ownership of developing the strategy – perhaps through the National Academy of Social Care. Part of the challenge, nevertheless, is to bridge the cultural divide with the NHS. Theoretically, social workers and care workers working in integrated partnerships can access HEE funded programmes, for example in leadership development. In reality, however, there is a significant cultural problem with NHS employers tending to ask for funding only for NHS staff. Leeds Health and Care Academy has had to insist, for example when local GPs asked for training for community and primary care nurses, that it would bid for HEE money only the courses were also available to care staff. They take a similar approach to leadership programmes, which are available to NHS, council, and care staff.

Registration of the workforce

I had expected to be recommending a register as part of this review. Some experts feel that a register would boost status, give the public greater confidence about safeguarding, and give employers confidence that staff have achieved a certain level of training. But not a single commissioner we have spoken to has raised the issue. Our conversations with providers have also found very mixed views. Funding is seen as a much higher priority – although the UKHCA reports that registration “is generally seen as positive in the UK administrations where it is already operating”.

“70% of our staff are over 50, if you told them they’d need to register to start work it would frighten some away, they’d rather work in Tesco”. A leading care provider.

I therefore am not sure that a register is an urgent priority, given the significant funding which would be required.

Defining the Workforce

The social care workforce is estimated to number around 1.6 million, of which 1.2 m is direct care staff and 84,000 regulated professionals including nurses.¹⁸ Even these figures may not capture all of the new roles which are being developed in response to needs in the community, including care coordinators, social prescribing link workers, some of the PAs hired by self-funders and the new groups of carers who are coming together through organisations like Shared Lives, a membership body which trains potential carers and matches them with adults who need support. These groups need to be thought about when considering whether to register the workforce.

¹⁸ Skills for Care, [‘The state of the adult social care sector and workforce in England’](#), 2021

Discussions of the workforce frequently overlook the role of relatives, friends and neighbours in care. Yet unpaid carers are a vital part of the workforce¹⁹: in many cases they are the social care system. According to Carers UK, 12% of the UK population provide care to around 8 million people. The monetary value of this informal care has been estimated at around £139 billion a year (Demos), suggesting that government must shore up the informal care system if we are not to unleash a vicious cycle of ever higher need and more spending. Arguably, some of the pressure on formal social care is coming from the extreme pressures that the informal system is under – including the decline of older people living with their families. The [current BEIS consultation on introducing a duty on employers to offer a week's unpaid annual leave to workers with caring responsibilities](#) seems unlikely to be the right answer, given that employers will need to backfill the roles and many workers are reluctant to take the time off.

To support informal carers financially, it will be vital to emulate Germany in enabling direct payments to be made to relatives (see Chapter 2). Alternatively, [the think-tank Demos has also proposed that full-time carers should receive a new benefit equivalent to Job Seekers Allowance](#), funded by abolishing Carers Allowance and relaxing the triple lock on state pensions. The repurposing of the triple-lock is worth exploring, especially in the context that Carers Allowance currently ends at 65. However, it is also clear that some full-time carers, many of them elderly people looking after elderly spouses, are in urgent need of respite. This does not always need to be financial: it can simply be access to good temporary care and reassurance that the loved one is being well-looked after.²⁰ When considering social care reform in the round, families need to be part of the story.

¹⁹ The Kings Fund, '[Securing Good Care for Older People](#)', 2006

²⁰ Carers Trust, '[Making Respite Real in Mental Health](#)'

Chapter 4. The Provider Market

The current landscape stems from the changes made in the Community Care Act of 1990, which transferred responsibilities to the private sector. The Act enshrined the principle that local authorities should assess individual needs and commission social care from the private and voluntary sectors. It was based on Sir Roy Griffiths' report, *Community Care: Agenda for Action*, which aimed to replicate the purchaser provider split of the NHS and make the state an enabler of care rather than a provider. Sir Roy did not treat social care in the same way as the NHS – intriguingly - because he valued the connection that councils had to their communities.

Since that time, there have been few sources of capital coming into the market. Local authorities have no capital to build care homes. Governments have built hospitals, not care homes. Some large providers are backed by private equity firms which have struggled to make the returns they expected; other investors continue to treat the market primarily a property play; there is the continual danger of exit undermining continuity of service. When Southern Cross collapsed in 2011, heroic work by the DHSC achieved continuity of service for residents. But the pandemic has raised the spectre of similar failures occurring again once corona virus support ends. The Chancellor promised the NHS “whatever resources it needs” but could not offer the same commitment to social care.

Over the same period, the gradual phase-out of many geriatric hospital beds has put additional pressure on care homes to look after a growing cohort of people with acute needs. The old lines between nursing and residential homes have become increasingly blurred, with more and more residents needing high level care. However, the staffing mix has barely changed in that period. The very fact that the NHS Long Term Plan included Enhanced Health in Care Homes pointed up the disgraceful fact that it is harder to get NHS help if you're in a care home, than if you're in your own home. During the pandemic we saw some geriatricians offering 24/7 consultations over zoom which was admirable; but this was by no means universal.

Over time, the market has become dysfunctional. National standards have pushed up costs, while budget cuts have resulted in councils driving unit costs down, to below the cost of provision. Margins are thin, many staff are on zero hours contracts, and cross-subsidy from private payers is the norm. While price pressure has undoubtedly led to innovation, the risk now is of a race to the bottom in areas where the tax base is too narrow and self-funders too few.

We need to attract new sources of capital into this market; we also need to define the market more broadly, including some types of retirement housing; and we need to bolster

the domiciliary care market, which is fragmented and not well understood by governments, but at its best can offer many of the solutions we seek.

The Shift Away from Care Homes

We know that the pandemic has hit care home occupancy rates – with the effect being temporarily mitigated by emergency government funding and some local authorities block-booking extra beds. Polls show increasing public anxiety about choosing care homes as a result of bad headlines during the pandemic. Some suggest that around 90% of people would prefer to receive care in their home²¹, and two-thirds of people prefer to die at home.²² [2020 polling by Policy Exchange and IPPR](#) suggests that COVID-19 has catalysed this trend: 31% of people polled during the pandemic said they were now less likely to want to put their relative in a care home.

This accentuates an existing trend. The number of care home beds overall has been falling since 2012. Nursing homes (which have a registered nurse on site at all times) have also been falling, though by less.²³

While there are good arguments for moving towards home care (see below), the trend away from care homes is not something which ministers should be entirely relaxed about. In particular, the chronic shortage of nursing staff is an existential threat. There are widespread reports of “care deserts” in some areas, where people in dire need cannot find a place.

A [report by Incisive Health for Age UK](#) sums it up well: “Some places do not have any nursing home beds or any easy access to them either. This is incredibly serious because older people who need a nursing home bed by definition have very significant health needs. As a result, in most cases they are unlikely to be able to be cared for at home, even if they have family members prepared to help and good availability of highly skilled domiciliary care. An acute shortage of nurses seems to be a principal cause of this problem, leading some nursing homes to de-register and become care homes instead, and others to ‘moth-ball’ some of their provision because they can’t staff it adequately anymore. This is a deeply worrying state of affairs”.

Some care home providers and investors are now privately considering moving more explicitly into the more specialist end of the market: dementia and end-of-life care. However, DHSC will want to monitor these shifts in order to ensure that there is sufficient capacity in the market to meet high acuity needs in the future. It will also be essential to attract longer-term capital (see below). If that does not happen, a radical alternative could

²¹ [Homecare Association](#)

²² IPPR, [‘End of life care in England’](#), 2018

²³ CMA, [‘Care homes market study’](#), 2016

be for the government to agree that very acute dementia/ Alzheimer's/ stroke/Parkinson's would qualify for free treatment under the NHS and reopen geriatric wards to care for sufferers. I have not seen this suggested anywhere; it would push costs back onto the state and clearly there would be a risk of moral hazard. But the closure of geriatric wards means that the system is exposed to the risk that we will run out of sufficient nursing home care in future, especially given the manifest reluctance of the NHS to send GPs and geriatricians into care homes. I am not sure that we have fully understood or planned for this risk.

Provider Viability

CQC's Market Oversight function is not comprehensive: it covers around 65 operators which are not always those at greatest risk of failure. It is also limited by commercial sensitivity in the timeliness of warnings it can give to central and local government. Some local authorities we have interviewed during this review have told us that they commission their own market research, to assure themselves about the viability of their local providers. This is duplicative. DHSC should consider developing its own in-house oversight function, using Companies House and other data, and relieving CQC of that responsibility – especially if CQC is to get a beefed-up role in oversight (see Chapter 2).

New Sources of Capital

In the medium-term, the government needs a more stable market. It also needs to be able to avoid subsidising private equity investors whose balance sheets are not entirely transparent, some who see it as a property play, and some who want to exit the market altogether. One answer to this would be to attract new sources of long-term, patient capital, e.g. from pension funds.

Longer-term investors, however, may want a more regulated market. In Japan and Germany, national price regulation helps to ensure long term stability of the social care market and gives national government's greater market shaping powers. As recommended in Chapter 2, a price regulator could give stability. This is not the role of the CMA, which is currently more of a commentator than an economic regulator.

Viewed this way, this market can be seen as a utility. It is not clear whether HMT would wish to set the capital investment framework for this sector, or even lend to it, to drive stability in the future. However, on that basis there could be a case for government to finance the building of care homes, and extra-care housing; perhaps in partnership with pension funds. This is a conversation worth having.

It would be wrong to assume that big, purpose-built care homes owned by chains always provide a higher quality service than some of the small, family-run businesses which have

long waiting lists. Larger operators can achieve economies of scale which smaller ones cannot; but some of these may also drive down wages. The CQC is understandably concerned about buildings and ease of access, but some families prefer the kindness and intimacy they get in small homes. Small operators find it hard to borrow for capital improvements, and many have sold up in recent years as they could not afford to renovate. In any market shaping policy, the government should aim to preserve pluralism of supply.

The Argument For “Home First”

Overall, there is a strong argument for shaping the market towards domiciliary care, so long as sufficient nursing home places can continue to be provided. [Evidence from other countries suggests that many people in England are in a hospital or care home when they do not need to be.](#) Home care is on average almost half as cheap as a care or nursing home, which is almost half as much again as keeping someone in hospital²⁴, implying significant potential savings. Home care can be of high quality and help maintain independence for longer, reducing demand for hospital or residential care.²⁵ CQC rates nearly 85% of community and domiciliary care providers as good or outstanding care compared to 75% of care homes.

In Japan, the social insurance system actively encourages families to keep relatives at home and out of expensive care homes. Its domiciliary care market is large and diverse, including both for-profit and non-profit services. The UK government should set a similar ambition of helping more people stay in their homes for longer as they age. Some of this will happen naturally, due to the trends above. However, government can also signal that it wants home care to be utilised more fully earlier in the care continuum, to help maintain independence (see Chapter 5), and play a role in prevention. It should also ensure that commissioners are not pushing people towards residential care as a result of the differential treatment of homes in the means-test. Age UK has suggested making “Home First” a legal right, within reasons. But there will be no need to go this far if people are provided with better information earlier, to help them make more informed choices.

Some commissioners who are focussing on person-centred outcomes and independence are finding that care home packages are reducing as a consequence:

“Somerset were the fastest place for reducing delayed transfers of care for part of 2018 - they were proud of their progress from a very high start to a lower number of delays. However, when they looked at their performance data, they also found that too many of

²⁴ NICE

²⁵ A Tessier, MD Beaulieu, CA McGinn, R Latulippe, [‘Effectiveness of Reablement: A Systematic Review’](#), Healthc Policy, 2016

those who were being discharged quickly were ending up in a residential care bed. For some of these people they had not had an opportunity of recovery or recuperation post their acute episode in hospital. They changed their discharge arrangements (to introduce more intermediate care beds) experienced a small increase in delays but, a significant improvement in the outcomes for older people, with many fewer being admitted permanently to residential or nursing care". Professor John Bolton, institute of Public Care

In England, however, the domiciliary care market is in crisis, with the number of hours of care provided falling by 3 million over the last 3 years.²⁶ In 2018 to 2019 only 21% of local authorities' long- term care budget was spent on home care, compared to 42% on residential care.²⁷ Domiciliary care needs to be much better understood, appreciated, and supported by government, if it is to bear the load of policy expectations.

For some people, domiciliary care can also mean living isolated at home, especially after a bereavement. If we are trying to maximise wellbeing, then staying in "their homes" should therefore also potentially mean downsizing into a retirement village, or extra-care housing.

The Role of Supported Living, Co-Housing, Retirement Villages and Extra-care Housing

To improve wellbeing in older age, and healthy life expectancy, any consideration of the provider market should include supported living, retirement villages, co-housing and extra-care housing or "housing with care". This is one reason why this review recommends that commissioning of ASC remains with local authorities – their links to housing will become ever more important as the population ages.

At its best, this kind of housing can be seen as an investment in public health. Demand is increasing – partly due to the pandemic. Anchor Hanover currently has a waiting list of 20,000.

Yet the UK has unusually few people living in these types of accommodation – around 0.6% compared to around 6% in the US, 5.5% in New Zealand and 5% in Australia²⁸

There is some evidence that these services, if well-managed, can play a useful role in keeping people independent. The think-tank IPPR claims that residents have a reduced risk of hospital admission, with unplanned hospital admissions down from 8–14 days to 1–2 days over a 12-month period. A report for the Audley Group by Aston University in 2015

²⁶ LaingBuisson, 'Homecare and Supported Living', 2018

²⁷ NHS Digital, '[Adult Social Care Activity and Finance Report, England - 2018-19](#)', 2019

²⁸ ARCO

suggested that their residents were a third less likely to be admitted to A&E and would be discharged in half the time, as they were able to move back to supported accommodation.

Earlier this year, a [report for the Extra Care Charitable Trust](#) found that some Extra Care residents had actually improved their health over 5 years, since moving into Extra Care facilities. The findings are:

- a reduction in risk of falls over the first 2 years of living in ExtraCare and no changes in the risk of falls
- the increase of frailty is delayed by up to 3 years in residents
- 23% decrease in anxiety symptoms
- improvements in memory and cognitive skills: 24% increase in autobiographical memory and 17% increase in memory recall tests
- 86.5% of residents were 'never or hardly ever' lonely: this is better than national averages

As a result, direct savings are being made to the NHS. According to this study, residents average 3 days less per year in hospital than previously. There are no expected increases in NHS costs over time as people age. Living in ExtraCare, it is claimed, saves the NHS around £1,994 per person, on average, over 5 years.

These findings are very powerful. They suggest that this type of provision is able to freeze some of the declines which are often assumed to be inevitable: functional abilities, cognitive function and frailty. It means that local authorities are wrong to resist planning permissions for this type of accommodation, mistakenly assuming they will bring unaffordable burdens to the local health and care systems. There is an urgent need to do more work here, to understand what the successful ingredients of provision are, and how we can accelerate roll-out.

Given the Potential Returns To Wellbeing, Why Aren't We Building?

One reason for the relative lack of this type of housing is that it is generally uncompetitive in the land market. There is no specific regulation or legislation covering "housing-with-care" in the UK, unlike in Denmark, the US, NZ and Australia. The sector says that the lack of category definition is a barrier to achieving planning permissions, as councils find it easier to back ordinary residential developments or care homes. The House of Lords Committee on Intergenerational Equity has recommended that the government clarify that extra-care housing should fall within the same use class – C2 – as care homes, which

would provide clearer guidance to local authorities. Some providers would like to see a new use class which would apply specifically to this market: between residential housing (C3) and residential care (C2). Clearly the use class will affect council taxes and business rates, minimum standards of care and CQC regulation.

ARCO, the sector's representative body, is in addition asking for changes to consumer rights legislation, where I understand that MHCLG has accepted the Law Commission proposals, including the impact on event fees, and leasehold reform. Ensuring that the sector can build mixed tenure properties will be key, I believe, to building stronger communities: this is normal in Northern Europe but often looked at askance in the UK.

There would be considerable benefits from establishing a joint DHSC-MHCLG-BEIS taskforce to look at these issues. However, it will be important not to draw the net too narrowly. Co-housing, which is very successful in Denmark and the Netherlands, is another model which can produce supportive communities of older people, but of which we have far too little in the UK, as it falls foul of the same council reluctance to grant planning permissions. One excellent example worth looking at is The Older Women's Housing Cooperative Group in North London²⁹, which took 18 years to achieve planning permission. The taskforce remit should not exclude that kind of development, as mentioned in the [MHCLG Select Committee's inquiry into housing for older people](#), which makes minimal demand on the public purse.

Unleashing the Consumer

In most markets, it is consumers who help drive market change. The care home and domiciliary care markets suffer from having very little cost transparency, no trusted intermediary like which, and from being too much of a distress one-time purchase. Decisions are made in crisis and are often bewildering. There are a number of small advisory firms, but these tend to focus on narrow segments of the market and charge fees for placing people within that particular segment. There is the additional problem that care homes are essentially a captive market: residents and families are extremely reluctant to provide negative feedback in case it rebounds on them.

Both the CMA and Citizens Advice Bureau have pointed to insufficient power for the consumer in the care home market. A Citizens Advice survey³⁰ of 510 people with experience of helping an older person arrange and pay for a care home place highlighted the following problems:

²⁹ Camilla Cavendish, 'Extra Time: Ten Lessons for an Ageing World', 2019, Harper Collins, pp 156-160

³⁰ CAB December 2019

1. Time pressure. Over half (55%) of the respondents to this research said that the entire process of arranging a care home place took under a month, and nearly 1 in 10 (8%) said it took less than a week. Just under half (49%) said they found the process of arranging a care home place distressing.
2. Older people and their families are both underwhelmed and overloaded by choice in the care home market. Families were overwhelmed by the number of variables to consider when choosing a care home and the lack of accessible information. Only 7% were provided with information about care home fees, for example through marketing materials or the website, prior to making direct contact. But they were also underwhelmed by the range of care homes. Almost 4 in 10 respondents (39%) said they did not have enough choice.
3. Charging practices in care homes can be confusing and unexpected. Over a third (36%) of respondents to this research were either not given a copy of the care home contract until after the resident had moved in, or not given a contract at all. Looking at billing practices specifically, the research finds that 1 in 5 (20%) people have experienced an unexpected additional charge, such as a back-bill or unexpected top-up fee, and over a third (37%) have put down a deposit for their room, despite the fact that care home residents lack the protections typically associated with this practice in the private rented sector.
4. People lack options to make their views known to care homes, even when they have concerns. Over a quarter (26%) of respondents to this research have had concerns about a care home provider, but only 1 in 5 (21%) of those who had concerns subsequently made a complaint. The most common reason for not complaining (highlighted by 37% of respondents) was the worry that this would result in negative treatment from the care home. But moving care homes is also not a realistic option for many - fewer than 1 in 10 (9%) moved care home as a result of their concern.

Ways forward could include creating a social care version of the anonymised NHS Friends and Family Test (although some settings are so small that all feedback will be easily traceable), revitalising CQC's role as a champion of the consumer, doing more to publicise CQC's ratings and creating an independent price regulator. The sector also needs to come together around some kind of national Trip Advisor service.

What Is Government's Role?

It would not be desirable for government to control a private market. Once the pandemic abates, ministers may welcome the fact that they are not, ultimately, responsible for every mistake in care homes. Moreover, the diversity and independence of the care home sector

is a strength. What government should be seeking to do is to drive more transparency to unleash consumer power, facilitate the construction of more supported living and extra-care housing, set an ambition for more care at home, and measure outcomes for those looked after in ASC, by acquiring the right data. The complexity of the market means that DHSC does not currently have robust data even on the number of people receiving social care. This needs to be corrected. Armed with much better data (see Data Chapter), ministers could assure themselves that the market was functioning without having to actually own it. However, there is a need for ministers to decide if they want to facilitate longer-term capital, and if so, work with HMT to achieve that.

Chapter 5: The Importance of Rehabilitation and Prevention

If our ambition is to help people maintain their independence for longer, thereby improving their wellbeing and reducing the need for social care, we need to look at what makes for effective prevention, and rehabilitation. These are often primarily thought of as the responsibility of the NHS but social care, especially domiciliary care, can play a greater role in reablement and the avoidance of hospital admissions.³¹ In fact the join-up between health and care around rehabilitation and reablement can be a trojan horse for improving the training and integration of the care workforce more broadly.

The impact on improving wellbeing, and reducing cost to the system, by focussing on keeping people independent for longer, can be very substantial indeed. Take the example of falls and fractures:

Reducing the incidence of falls and fractures could save money and improve wellbeing. In the UK, around 10% of all ambulances are called out for over-65s who have fallen over.³² It is estimated that falls cost the NHS around £1 billion a year.³³ Around half of those who fracture a hip in a fall subsequently become dependent on others for daily living, due to losses in confidence and mobility – which can in turn increase the demand for health and social care services.

Tackling this can be relatively simple in many cases, given that poor muscle strength and balance are the 2 most common modifiable risk factors for falls. Strength and balance training has been shown to halve the risk of falls.³⁴ It also strengthens muscle and bone density, making fractures less likely even if someone does fall over.³⁵

The table below (figure one) shows that injuries account for 3.4 million NHS bed days, half of which is the over-65s³⁶

³¹ The Kings Fund, [‘Home care in England: Views from commissioners and providers’](#), 2018

³² Age UK, [‘Falls Prevention Exercise, Following the Evidence’](#)

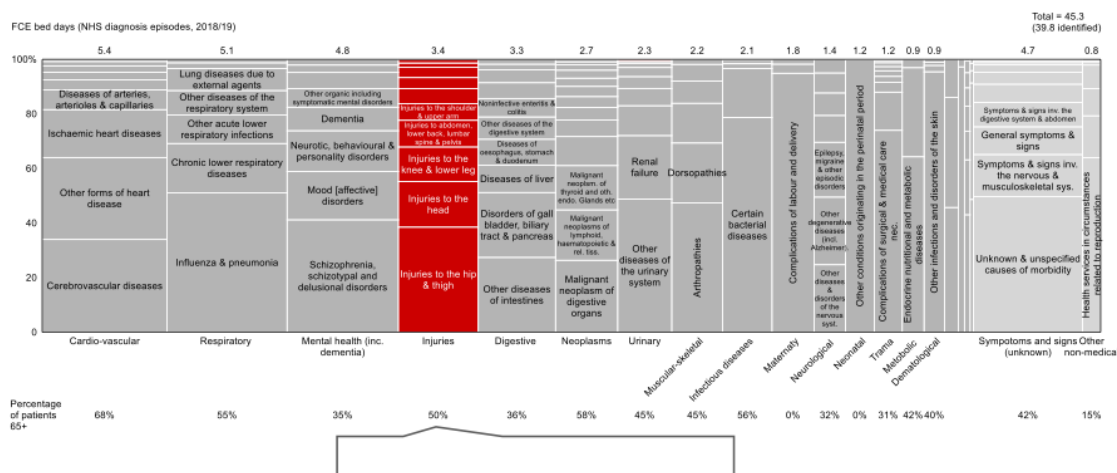
³³ J Leal, AM Gray, D Prieto-Alhambra, NK Arden, C Cooper, MK Javaid, A Judge, [‘Impact of hip fracture on hospital care costs: a population-based study’](#), Osteoporosis Int., 2016

³⁴ Royal College of Physicians, ‘Exercise for Life: Physical Activity in Health and Disease’, 2012

³⁵ LD Gillespie, MC Robertson, [‘Interventions for preventing falls in older people living in the community’](#), Cochrane Database of Systematic Reviews, 2012

³⁶ NHS Digital

Figure one



[Figure one shows a breakdown of health problems and how many NHS bed days were accounted for by each illness in 2018 to 2019. The schematic also displays the percentage of patients aged 65+ for each group of illness.]

A number of falls prevention programmes have been found to be cost-effective. These include Otago home exercise; Falls Management Exercise group programmes; Tai Chi; home assessment and modification.³⁷ New technologies are also producing new solutions: one company works with OTs using gaming software to improve balance in a range of age groups. It claims to have made statistically significant improvements in balance and pain among people who played the games 3 times a week for 12 weeks.³⁸ In addition, Care England claims that installing acoustic monitoring can significantly reduce the number of falls and hospital admissions, as well as giving care staff back 40% of their time.

This would suggest that evidence-based strength and balance services should be commissioned throughout the country, to reduce risk of falls.³⁹

We should consider how social care could play a more significant role, given that all of these interventions can all be done in the home or in the community in partnership with physios and OTs. The international and domestic evidence shows that successful

³⁷ Public Health England, 'A return on investment tool for the assessment of falls prevention programmes for older people living in the community', 2018
³⁸ EK Stanmore and others, "The effectiveness and cost-effectiveness of strength and balance Exergames to reduce falls risk for people aged 55 years and older in UK assisted living facilities: a multi-centre cluster randomised controlled trial", BMC Medicine, 2019
³⁹ Public Health England, 'Falls and fractures: consensus statement and resources pack', 2017

prevention and reablement is not merely a medical intervention but a social one as well: it requires building the confidence and engagement of individuals and getting them to take responsibility. Age UK and some council Leisure Services are already important actors in this space. Some social care workers have already taken extra training to become reablement support workers. This is an area which offers the potential for social care workers to break away from “doing to” and “doing with”. Some international evidence suggests that care workers become more motivated and satisfied with their jobs when they are involved in positive rehabilitation, not simply managing decline.

ASC can also have impact through housing adaptations. Housing associations and extra-care providers can help keep people in their homes for longer if they work in partnership with local health and social care services to identify those at risk and install adaptations. Despite hard work by some councils, failure to fit adaptations or take other preventive measures costs the NHS over £400 million a year.⁴⁰

Above all, however, we need to offer older people a sense of purpose and social connection. There is a clear journey from bereavement and isolation to poor health to reliance on social care. Unless we understand the psychological aspects as well as the physical ones, we will never solve this challenge. Good commissioning understands both.

“Loneliness is one of the biggest reasons people end up in care homes. If you’re lonely, you don’t eat, you become frail; you fall” Care Home Investor

The task is urgent. According to the CMO, adults 65 years and over should undertake balance and co-ordination activities on at least 2 days each week. But the 2016 NHS Digital Health Survey England found only 34% of men and 27% of women aged 19-64 meeting the guidelines. Over 65 the numbers fell to 13% of men and 10% of women.

It is generally advised that programmes should involve at least 2 hours a week, for a minimum of 6 months. But strength and balance exercise programmes delivered by NHS falls rehabilitation services often stop after 6 weeks. In 2012, 73% of NHS patients supervised at home were on programmes lasting for 3 months or less⁴¹ which does not provide a sufficiently high exercise dose.⁴²

This makes it vital that people can transition from NHS-based programmes to community-based ones, which continue to deliver challenging balance and strength training.

⁴⁰ H Garrett and others, ‘The cost-benefit to the NHS arising from preventative housing interventions’, 2016

⁴¹ Royal College of Physicians, ‘Older people’s experiences of therapeutic exercise as part of a falls prevention service-patient and public involvement’, 2012

⁴² C Sherrington and others, [‘Exercise to prevent falls in older adults: an updated systematic review and meta-analysis’](#), British Journal of Sports Medicine, Vol. 51(No. 24), 2017

Covid is increasing the need for rehabilitation services

The pandemic is only going to put further pressure on existing community health services and rehab systems:

- Even those not admitted to critical care may suffer decline in muscle mass and strength.
- Between 25% and 50% of individuals who required critical care in hospitals due to COVID-19 are likely to experience intensive care acquired weakness. When discharged and in the community, patients may experience physical difficulties for up to 5 years.
- Around 60% of individuals who required critical care and ventilation in hospitals due to COVID-19 will require ongoing care and support for post-intensive care syndrome (persistent physical, cognitive, and psychological impairments). These individuals will likely require significant, ongoing physical rehabilitation (averaging at 28hrs per package, usually conducted by community/district nurses) and critical care follow-up clinics, with onwards referral from there if required.
- Support with diet/nutrition to aid recovery: particularly those who have suffered cardiac distress, pulmonary distress, or those who have been critically ill due to the weight loss, frailty or sarcopenia associated with these conditions. This will place an increased demand on primary care services with the potential for readmissions.⁴³

DHSC is discussing with NHSE the need to update the 2016 NHSE guidance⁴⁴ to improve commissioning of rehabilitation.

The Need for Greater investment in Community Health Services

CHS accounts for around 10% of total NHS spend. However, spend is not keeping pace with demand. And there are serious shortages in some key staff roles. Long before COVID-19 we were seeing alarming shortages of the community and district nurses who are often responsible for overseeing a person's rehabilitation package in their own home and in care homes. While the total number of staff working in community settings has increased since 2010, it has not kept pace with activity. We have seen a 41.9% drop in district nursing since 2010; and a 13.1% drop in community nursing (DHSC modelling see

⁴³ DHSC briefing

⁴⁴ NHS England, '[Commissioning guidance for rehabilitation](#)', 2016

chart). The challenges of recruitment and retention are aggravated by the fact that nearly 20% of CHS staff are aged 56+ (NMC, 2018).

Table one

CHS Staff Group	Mar-10	Dec-19	Mar-20	2020 numbers compared to 2010 numbers
AHP Total	59,070	69,131	69,483	10,413
Dietetics	3,298	4,370	4,398	1,100
Occupational Therapy	13,751	15,575	15,683	1,932
Physiotherapy	17,721	20,033	20,175	2,454
Radiography (therapeutic)	2,018	2,938	2,958	940
Art / Music / Drama therapy	456	397	405	-51
Speech and language therapy	5,799	6,272	6,366	567
District Nurses	7,704	4,426	4,415	-3,289
Community Nurses	38,999	35,809	34,196	-4,803

Much can be done to raise the profile of the importance of these services, to incentivise Band 5 nurses, and also to change the skill mix of staff. (see Chapter 3).

Even when falls do occur, or strokes, or other diseases, rehabilitation can make the crucial difference between whether or not someone is able to return to independent living. Yet [one NHS study](#) claims that 40% of demand for rehabilitation (following major trauma alone) is not being met.

The proportion of older people receiving reablement/rehabilitation after discharge from hospital fell from a high of 3.3% in 2013 to 2014 to 2.7% in 2016 to 2017 (NHS Digital 2018). Since then, both the number and proportion of older people receiving reablement/rehabilitation has increased, but at 2.9% the proportion is still below its peak of

2013 to 2014. This suggests that while more reablement/rehabilitation packages are being made available, investment is failing to keep pace with rapidly rising demand.⁴⁵

The evidence also suggests significant regional variation in access to reablement/rehabilitation. Spending on services known as ‘ST-Max’ – short-term services intended to maximise a person’s independence and minimise their need for ongoing support – ranges from £322,614 per 100,000 adults in the East of England to £963,419 per 100,000 adults in the East Midlands.⁴⁶

Ingredients of Successful Rehabilitation

We have looked at examples around the world, and domestically, to try and assess what good looks like. The most successful rehabilitation programmes include the following:

1. Engaged participants signing up to goal-oriented programmes which require them to work towards those goals. Good rehab is done with and by participants, not to them.
2. Intensive: The best programmes are hard work for the participants, and involve activity several times a day.
3. Partner with both the patient and the family.
4. Time limited: from the outset a date is set for transfer to long term solutions, since there are diminishing returns.
5. Balance between the medical-oriented model and the social-oriented model. Differing approaches can lead to real clashes which need to be resolved at commissioner level.
6. Outstanding data management: joined up electronic health records.

This last point is crucial. To maximise the potential of rehabilitation, it is vital that care records are digitally enabled and shared across settings and that all relevant staff are able to access them and trained to use them.

“Rarely has this country or, for that matter, any other country achieved a single electronic health record, which is shared by all practitioners... [let alone] expecting patients to be contributing to their record... [which is] increasingly [vital] when patients transfer their care

⁴⁵ Age UK, [‘Health and Care of Older People in England 2019’](#), 2019

⁴⁶ Ibid

out of hospital. I say this as being able to partner with the patient and the family becomes really important [for effective rehab], and for them to feel that their contribution is worthwhile. If a shared clinical management plan is to be successful then patients, particularly those needing to be helped to change their lifestyle choices, need to be given regular feedback on what they're doing and how they're doing. This is enabled [by having systems which are not closed and inaccessible] so, having an ability to offer some form of call centre coordination, where [the single point of contact] has access to information about the individual [is transformative]. This would be better than a patient making regular calls to a GP who may refer them to a hospital for assessment...”

Sir David Dalton, former CEO, Salford Foundation Trust.

Examples of Successful Programmes

These examples suggest that the setting – ranging from hospital to residential home to home - is far less important than the staffing and intensity of the programme.

1. Australia's Transition Care Programme

This programme focusses on optimising independence and wellbeing and provides each patient with a goal-oriented plan covering both their physical and cognitive needs.

Where: provided in a facility or in the recipient's home

Length of stay: average 7 weeks; maximum 12 weeks.

Services provided: very broad ranging, includes standard social care and nursing support, plus therapy. Recipients are entitled to:

- clinical services including wound management, dementia support, medication management, establishment and maintenance of tubes and catheters (carried out by registered nurse)
- low intensity therapy including physiotherapy, occupational therapy, podiatry, dietetics, and speech pathology
- psychological or counselling services
- daily living assistance: help with personal hygiene, continence management, eating, dressing, mobility, and communication
- advocacy

Social care: Independent report by Baroness Cavendish

- social activities: arranging / encouraging social programs and activities that help to prevent isolation and promote the dignity and wellbeing of participants
- support services to maintain personal affairs

Funding: Means-tested co-payment system maximum recipient co-contribution is \$11 per day for at home care, \$53 per day for residential care; fully funded by the government for those unable to pay

Effectiveness: “The model is configured and targeted in accordance with programs reported in the international literature to be effective.” [BMC Geriatrics]

2. New Zealand: CREST Rehabilitation at Home

Where: a home-based rehabilitation programme following a hospital episode; care delivered in recipient’s home by community providers

Length of stay: Provides up to 4 visits a day, 7 days a week

Services provided: nursing services, OT, physiotherapy, and daily social care support

Funding: fully government funded and free for recipients to access

Effectiveness: “Initial results do, however, suggest a 7% reduction in the number of over-65s arriving at the emergency department following a fall.” [The quest for integrated health and social care: A case study The Kings Fund]

3. South Warwickshire CCG: NHS Rehab in private care home

Where: Private care home (£1.1 thousand to £1.3 thousand per room per week) which provides rehab care packages to NHS hospital discharges

Length of stay: Rehab package structured a 4 to 6 week stay at the home; with beds bulk booked by NHS trust

Services provided: Onsite NHS provided physio and OT (3 to 4 sessions per day). (However, rehab intensity has been variable, due to significant delays in local authority responses to funding requests)

“The [physio and OT] were paid for by the NHS which was the only way they could get the home to offer it as a service – they didn’t have enough private demand to justify [hiring them].” [Social care nurse Warwickshire]

4. Nottingham Rehabilitation Centre step-down unit within hospital

Where: Step-down unit for post-ICU patients before returning to the ward

Length of stay: Between 2 and 7 days

Services/staffing: An example 12-bed ward is staffed with 3 physios, 3 OTs, 1 SALT, 1 dietician, 1 psychologist per 8hr day in addition to 24hr nursing staff and doctors

Effectiveness: Significant improvements in clinical outcomes tracked from unit admission to discharge:

- >90% patients walking independently on discharge (avg. ICU mobility score increases 6 to 9)
- Average physical assessment score increases from 31 out of 50 to 44 out of 50 • Independence in daily activities
- Average ↑ FIM/FAM score >110% (increase from “moderate assistance” to “supervision / verbal prompting” across 30 daily activities)

“It is amazing to see some of them speak to their families for the first time, enjoy a first cup of tea in weeks and take their first steps” (Staff member)

“They would sit and listen to my stories, tell me what was going on in the outside world; I really cannot thank them enough and will never forget their dedication and help” (Patient)

5. NHS Somerset and Somerset County Council Partnership

This joint commissioning group used the Vanguard method (see Chapter 2) to develop a reablement programme. They invested more time and money upfront to understand patient problems that need to be solved to improve the patient’s life, with the aim of savings time and money later. A new integrated support services team was set up that included interdisciplinary team members of health and social care providers. Referrals, selection criteria, assessments and paperwork were streamlined. The programme focused on helping people solve their own problems while delivering care with targeted light

touches. It has achieved improved outcomes for 30-day readmissions and social care costs.⁴⁷

6. Raising the Profile of Rehabilitation and Reablement

NHSE's appointment of a National Clinical Director for Rehabilitation Services (who is also the Chief Allied Health Professions Officer) is a welcome first step towards raising the profile of these services and attracting more staff. However, there is a strong argument for a communications campaign which would explain the vital role these services play.

7. NHSE's Proposals for Hospital Discharge and Community Care

NHSE's proposals present an important opportunity to further improve the join-up between health and social care, and to focus on outcomes and the wider determinants of health. There are 3 parts to the proposals: (i) maintain the discharge service instigated during the pandemic; (ii) bring forward capacity increases; (iii) Create additional rehabilitation bedded capacity. The proposals to create a single coordinator role across discharge and community care, and to deliver a period of non-means-tested support of integrated health and social care, are very positive.

To maximise the potential of this initiative, and drive integration, NHSE should ensure early involvement from care providers. Introducing social care workers to patients in bedded rehabilitation facilities early could help patient reablement and allow trust and continuity to build. This could mean having acute trusts having a list of trusted providers, in partnership with the local authority.

If the NHS is intending to roll out Seacole Centres at scale, with new buildings, consideration should also be given to whether it would be better to use existing care homes with modern facilities and falling occupancy. "At the start of the crisis we offered the NHS 700 brand new care home beds which could be isolation units, but they were not used. Why not? Hong Kong put Covid patients in isolation care homes; no one has died in a care home in Hong Kong". Professor Martin Green, CEO, Care England.

Seizing the Opportunity to Have the Care Conversation

The other big opportunity the NHSE proposal represents is to use the period of non-means tested step-down care to engage families, to think through the longer-term options for

⁴⁷ TVHKT, 'Reablement programme Somerset'

care, rather than – as now – being faced with having to make difficult decisions in crisis, in the almost total absence of information about the care market.

[Recent research has found a majority of people saying it was difficult to find the right information \(56%\) and found the care system complex to find their way through \(78%\).](#) It is perhaps not surprising that more than three-quarters (77%) said they found the process stressful.

Repeatedly, anecdotal evidence suggests that there is a gulf between rehabilitation and social care. This goes back to lack of trust and understanding between the public and private sectors. The NHS will not recommend care providers and often has little understanding of them. The CQC is reluctant to publicise well-rated services beyond its website. Many people are left in a time of crisis, completely on their own. One woman who wrote to me is a full-time carer for her husband, who was diagnosed with a complex, degenerative neurological disorder at the age of 61. She praised the excellent medical care he has received but says that she has never been informed by either a health or care professional about relevant services including attendance allowance, carers allowance, district nurses, day hospice, counselling, wheelchair services and community physios.

With the public more aware of social care since the pandemic, this is the time to communicate the choices and help to give consumers more say, more power and more control, in partnership with consumer organisations including [Homecare](#).

Key questions To Explore Further:

1. How can we build a market around ongoing care, where providers are incentivised to rehabilitate and reduce care over time? Hertfordshire Council is able to achieve this because it has sufficient demand that it can offer more contracts when providers get people off their books – however this may not be the same in deprived areas with few self-funders.
2. What is the ideal length of time for non-means-tested rehabilitation under the BCF, and beyond? If the aim is to avoid doing assessments or talking to families about funding in the hospital bed, it might be 2 weeks. If the aim is to minimise public spend overall, and get people back on their feet again, it might be 6 weeks. Beyond that, there may be diminishing returns, but interventions in the community may still be cost-effective.
3. What is the best way to provide more comprehensive and timely information to families about ongoing care choices, during rehabilitation?

The Role of Social Care in Prevention

I have written separately to the Secretary of State with suggestions about how to prevent chronic disease and obesity. For the purposes of this review, the narrower question is what role social care could play in promoting exercise and better diets, overcoming loneliness and boosting social connection.

In one sense, social care is all about prevention already: by building relationships, and helping people stay mentally and physically as well as they can be. The best, asset-based approaches, including those detailed in Chapter 2, encourage behaviours which promote good health, and build communities to support this.

However, this is often overlooked because prevention, especially primary prevention, is not explicitly part of social care's official role. [Skills for Care](#) has found low take-up of training in prevention, possibly because providers are not commissioned to provide it. Prevention is, however, part of the explicit role of various new actors with whom care workers may cooperate social prescribing link workers, trusted assessors, care navigators, care coordinators, local area coordinators, wellbeing advisors and lifestyle coaches. Care staff may work with all of these or indeed seek to transfer into any of these roles. Part of the story about social care needs to include prevention.

Section 2 of the Social Care Act 2014 states that local authorities must:

(1) provide or arrange for the provision of services, facilities, or resources, or take other steps, which it considers will—

(a) contribute towards preventing or delaying the development by adults in its area of needs for care and support.

(b) contribute towards preventing or delaying the development by carers in its area of needs for support.

(c) reduce the needs for care and support of adults in its area.

(d) reduce the needs for support of carers in its area.

There is potentially a powerful role for Health and Wellbeing Boards in delivering against (a) through the networks being proposed by Sir Muir Gray. Using the new Public Health England specification for living longer better, Sir Muir is proposing that each network would produce an annual report for its population, using a single set of criteria, with the networks learning from one another as a community of practice. The networks would take the lead in changing the culture from one which expects older people to be viewed only as passive

recipients of ‘care’ to one that sees them as a subgroup of the population consisting of individuals with potential to make an even greater contribution.

“The network would just need to prevent one person being admitted to residential care to recover the cost” Sir Muir Gray.

This seems to be an excellent proposal which deserves support.

Ensuring that the care workforce plays its maximal role in prevention, as part of one united workforce, will require the development of proper outcome measures. The [report of the APPG on Longevity](#) argued in February 2020 that we need a single measure for tracking health span and lifespan to track progress. The “HealthSpan” indicator currently being developed by Outcomes Based Healthcare with Public Health England and NHSE/I is based on anonymised GP practice datasets and can be interrogated down to PCN level. Ultimately, the goal is to enable commissioners, CCGs and PCNs to track the HealthSpan: Lifespan ratio, in almost real time, together with capitated acute expenditure. It is not yet clear whether this initiative will be extended to include spending on community, mental health, and social care but it must. In this way, we will be able to relate improvements in health span to the whole of the care continuum.

Chapter 6: Data Flows

During the pandemic the lack of accurate and timely data became a real problem for orchestrating an effective response. The DHSC did not even have a list of all care homes. Simultaneously, attempts by a wide range of actors to chase data was overwhelming for providers who needed to spend time with families and customers, not public agencies calling them incessantly for information.

Going forward, the DHSC needs much better oversight of the system through a new data regime which gives DHSC, commissioners, providers, and consumers the right information in the least burdensome way.

The Challenges

Problems with the data in social care range from the way it is collected to the quality of the data itself. The problems can be categorised as follows:

1. Burdens and duplication. Providers face too many different asks from CQC, Local Authorities, CCGs, Skills for Care, NHS Digital and the Department of Health and Social Care. Fulfilling these requests creates unnecessary costs in the system and takes too much time away from care. We have heard from both providers and local authorities that each local authority has different data requirements for providers, which places a burden on the provider's branch staff to collect the data and the central staff to coordinate. This is especially true for providers who work across many different local areas and must adhere to different requirements for each jurisdiction. Providers which work across the UK regions additionally face the problem that CQC and its peer regulators do not share a common dataset. Further, there are several overlapping data collections; for example, 2 local authorities (Hertfordshire and IoW) told us that the CQC data is 75% identical to the data they collect. If CQC would share the data, there could be a single survey and thereby reduce the burden on providers. Failure to share information also leads both local authorities and CQC to carry out separate user and carer surveys with the same providers. This wastes money, leads to survey fatigue and provider overload.
2. Poor data quality. One local authority told us that in their experience data quality has worsened under austerity, as many councils have cut the number of people who work on it. Without regulation or audits, they said, there is no incentive for many local authorities to fix this problem. There are also methodological flaws in some data because of a lack of understanding about the way the care market operates. During COVID-19, some providers felt that the capacity tracker conflated care home vacancies with suitability (just because a room is available does not mean it is appropriate or suitable for a given individual).

3. Gaps in the data.

a. Financials. Insufficient information on funding flows means it is not possible to track funding from DH to local authorities to providers to outcomes, making it difficult for DHSC/MHCLG/HMT to judge return on investment. There is no data on self-funders, who are estimated to make up 41% of people receiving care.⁴⁸ Yet it's important to know about this group for 2 reasons: 1. A number of self-funders eventually do fall on the state, so present a financial risk that local authorities should know about, and 2. Self-funders use the NHS, so data on them is needed to join up services and properly implement preventative care.

b. Impact of money. The lack of data on outcomes makes it impossible to evaluate the impact of spending. We heard from both local authorities and providers that the vast majority of the data local authorities that request focuses only on time-on-task, not outcomes. Further, there is no standardised set of 'good' outcomes across local authorities : so for 152 local authorities there may be 152 versions of what 'good' outcomes look like. When discussing ASCOF's role in measuring outcomes we heard from a number of local authorities , providers and researchers that it is limited in its usefulness for a number of reasons, most notably that it was created before the Care Act 2014 so lacks the focus on wellbeing and user perspective. We are aware that DHSC is leading a project to "refresh" ASCOF and put this right: this work needs to be completed urgently if a workable national framework is to be created.

4. The market. Very limited information on supply, demand, and fees makes it difficult for local authorities to fulfil their market shaping duties and for DHSC to judge market fragility. There is currently no data on how many clients domiciliary care providers have, how big the unregulated care market is, or how many self-funders individuals' providers serve, making it hard to model future need. We heard from one researcher that future demand is almost entirely based on census data and takes little account of levels of need. There are also significant gaps in workforce data. High turnover rates make it hard to get consistent data on levels of staff vacancies, especially in domiciliary care – something which is not always understood by public agencies - but there should be up-to-date information on the number of services lacking registered managers, given the important impact that RMs have on care quality. Another piece of the puzzle missing is the informal care market, where there is very limited data even though it is valued at an estimated £58.6 billion – £100 billion.⁴⁹ Lack of funding flow information generally makes it difficult for DHSC/HMT to judge return on investment,

⁴⁸ Local Government Information Unit '[Independent Ageing: Council support for care self-funders](#)'

⁴⁹ National Audit Office, '[Adult social care at a glance](#)', 2018

compounded by the fact that ASC budgets are not ringfenced and the information is collected only once a year.

5. Lack of transparency stemming from commercial and regulatory concerns. Our interviews have picked up an unwillingness to share data locally, regionally and nationally. There is a further lack of co-operation between some providers and local authorities, with some care homes reluctant to publish their true vacancy levels in order to retain the option to fill vacancies with self-funders, and many local authorities reluctant to give out the number of people waiting for assessments, or the numbers of people who have been assessed and are waiting for a care package. At the moment the only way to access this data is through FOI. Lastly, the lack of integration of health and social care data makes it difficult to forecast future demand.

6. Timeliness. The King's Fund, Institute for government and other researchers have told us that clean social care data is often not available quickly enough for analysis to be useful in a meaningful timeframe. The King's Fund mentioned that publication can end up being 12-18 months after the data was collected, mainly because it takes so long for DHSC itself to get the data. This in turn, is caused by the large volume of paper returns still being used by number of providers: according to the Health Foundation, around 2/3rds of providers are not digitised.

7. Outcomes are hard to measure. Data collected by local authorities almost exclusively focusses on time on task rather than outcomes.

A classic example of what providers experienced during the pandemic was quoted as follows:

“Currently I complete a daily tracker with staff and PPE info. My local authority have a very similar form ask for PPE and staffing info to be completed twice a week. The commissioning team phone daily asking for, yes you guessed it, staffing and PPE. And now the palliative care team phoned and said they will be asking us daily for the same info. Surely in this day and age of technology all the info we are sharing should just be sent to one central point?!”

As the CQC states, in *The Next Ten Years for ASC Data Quality*: “there are lots of organisations asking social care services for information. The CQC, Local Authority, NHS, local commissioners, wider local stakeholders, as well as DHSC. There remains no single point of collection within ASC. This is made more difficult by a series of disparate systems being used in the sector, but a smart solution must be possible. Having one place to provide information would be invaluable for care providers”.

That central point is now urgent – and technology makes it easier than ever to create, even in the fragmented social care market, if the National Academy for Social Care (see Chapter 3) is tasked with supporting providers to develop the requisite systems and expertise.

What Do We Want to Achieve?

1. Improve care quality.

- a. Track outcomes. We need sufficient outcomes data to support commissioners move away from time-on-task and towards outcomes-based commissioning. Tracking outcomes should help improve trust between commissioners and providers. This will also allow the centre to hold commissioners to account for delivering good outcomes.

- b. Market transparency. We need to improve market transparency to empower consumers to choose the best and most appropriate care for them, and secure long-term continuity of service.

- c. Integrate NHS and SC data. Better integration of NHS and social care data will improve the patient/user journey.

2. Reduce the burden on providers and costs for all system actors. All reforms to data should be considered in the context of reducing the burden on providers. We need data collection processes to be streamlined and standardised to lessen this burden. Ultimately the goal should be to provide standardised and timely data that can long-term be extracted through machine learning.

3. Shape the market. DHSC and local authorities need sufficient data on current and future demand, supply, fees, and margins to monitor provider fragility and shape the market, without responsible local authorities having to commission their own studies to fill in gaps left by CQC.

What Data Matters Most?

Deciding what data is most important should be determined jointly by DHSC, providers and commissioners. Below is a starting point for a conversation which should include providers at an early stage, to understand what is feasible.

1. Outcomes.

a. Individual user-defined outcomes should be created with the individual receiving care, their family, and friends, allowing the individual's experience to be tracked. This model already exists in the Netherlands. TLAP's "I Statements" can help individuals set their outcomes, for example:

- Wellbeing and Independence
 - "I can do the things that are important to me"
 - "I am treated with respect"
- Information and Advice
 - "I can get information and advice about how I can be healthy"
 - "I know about things that are happening in my area and groups I can join"
- Active and Supportive Communities
 - "I have people who support me"
 - "I can go to local groups and activities and feel safe"
- Flexible and Integrated Care and Support
 - "I can plan the care and support I need with people who know and care about me"
 - "I know how much money there is to pay for my care and support and how the money is spent"
- When Things Need to Change
 - "I have a plan for when I move or there are big changes in my life"
 - "If my medicine has to change, I know why and can say what I think about it"
- Workforce
 - "I am supported by people who value me for who I am"

- “I am supported by people who listen to me, so they know how I want to live my life”

It is possible also to set individual person-centred outcomes for carers and providers, which they can track themselves against. TLAP’s “We Statements” are useful here:

- Wellbeing and Independence
 - “We talk with people about what they want from life”
 - “We help people to get together in groups to share their stories and ideas”
- Information and Advice
 - “We give information that is up-to-date and in different ways depending on what people need”
 - “We talk to people to find out how much information they want”
- Active and Supportive Communities
 - “We make sure that people can keep in touch with family, friends and people important to them”
 - “We work with local organisations to make our area friendly and welcoming to everyone”
- Flexible and Integrated Care and Support
 - “We work with other organisations to make sure people have one plan”
 - “We work with people as equals. We all share what we know to help make decisions together”
- When Things Need to Change
 - “We support people to plan for big changes in their lives, so they have enough information and time to decide what to do”
 - “We make sure staff in new places, or places where someone will be for a short time, know what support people need and want”

- Workforce
 - “We don’t make guesses about what people can or cannot do. We don’t stop them from having choices”
 - “We know what is important to people and make sure those things happen”

b. Standardised system-wide outcomes to measure the broader progression of the sector and give insight into population wellbeing, enabling DHSC to know, for example, how 80-year-old diabetics in Sunderland fare relative to their peer group in Bristol. These outcomes should be co-designed with national government, local authorities, and providers to ensure they are appropriate and comprehensive, building on the Care Act 2014 Regulation 9. Currently, ASCOF is used to standardise “good” outcomes and track performance: this is being updated by ADASS/IPC to provide more consistent and relevant data. There is an imperative to consult providers fully here.

- Quality. User/family and friend reviews could enable a “Trip Advisor” style system allowing people to better find/chart their own care. (see Chapter 3).
- Market Stability. More visibility is needed of cash flows, leverage and provider margins to understand the fragility of the market and the regions in which it is most fragile. High-level data on self-funders is needed and on fees.
- Expenditure. For DHSC to better understand impact of spending, it needs more detailed, timely information on the allocation of funding. The ASC Finance and Activity Report provides a lagged annual breakdown, which makes it difficult for DHSC to track how money is spent during crises.
- Workforce. DHSC needs a better sense of macro vacancy and retention levels across the sector to respond to workforce shortages. One way to achieve this would be to make compliance with Skills for Care’s ASC-WDS compulsory. Containing 25 questions, it is not seemed overly onerous.
- Shaping of the market. Commissioners with a duty to shape the market will need some data on fees, numbers of self-funders and LA-funders, and unmet need. An independent price regulator is used in Germany to implement a price floor, which provides long-term certainty for providers and stops a “race to the bottom”. A similar model has been suggested to us by both providers and local authorities.

Barriers to Collecting the Right Data

Many providers still use paper systems. We heard from both a number of providers and local authorities that many providers have not yet switched to an electronic data collection system, which mean it is not easy to aggregate it or get it in a timely manner. According to the Health Foundation, 2/3rds of providers are still using paper systems.

Lack of tech skills in care workers and significant time constraints. The care workforce is digitally under skilled. In addition, more than half of providers have 10 or fewer staff, which means that digital skills can be few and far between. Training is needed in, for example, electronic record keeping, inputting, and training on information governance standards. During COVID-19, NHS mail was introduced without information governance requirements, and video conferencing without DSPT standards. Installing electronic data collection systems will not provide accurate and timely data unless carers know how to use them properly.

- Commercial confidentiality and lack of trust. Problems in gaining information are not limited to systems. We heard from CQC that some local authorities do not want to quantify the number of people waiting for assessments or for care as it reflects poorly on them; often CQC has to FOI local authorities, which ultimately, they do have the legal duty to provide. However, this is a waste of time and taxpayer money. Equally, some care homes do not want to share their vacancy numbers because it is more profitable for them to fill those vacancies with self-funders. Introducing an independent price regulator to moderate fees could be one way to start addressing these perverse incentives. But more thought needs to be given to the very real confidentiality issues here, and to understand these issues from both sides.
- There is a fragmented IT system market. Providers tell us there are a vast number of IT system providers in the sector, which use different platforms and have different compatibilities. If the data and systems aren't standardised, then it will prove very difficult to aggregate data. We also heard that different local authorities integrate different data (for example, some integrate ASC and housing, others integrate ASC and children's social care, others have ASC completely separate), this makes it difficult to aggregate out the relevant data for ASC.

Recommendation 1: Create a national data framework

A national framework would outline the basic requirements for data collection across every local authority, including a standardised set of 'good' outcomes building on the refreshed ASCOF. This would reduce the burden on providers who interact with more than one local

authority and would standardise the system wide outcomes. local authorities could add limited data requirements on top of the national framework to account for local circumstances, but this must not be overly burdensome.

This model would build on the East of England model, in which 11 councils collectively created a common contract for providers to reduce the data burden.

The national framework should be co-designed with input from national government, local authorities and providers to make appropriate decisions about what data is necessary and how best to ask for it. The ultimate goal in the design process should be identifying ways to reduce the overall burden on providers whilst filling in the gaps in the data.

Although the framework should be designed at the national level, it should be delivered at the local level, with data collected maintained by the local authorities. This would replace the currently fragmented local authority data collection requirements and make it easier to aggregate trends and outcomes. The national framework would be mandatory for local authorities to use and must replace older data collection requirements. Clear metrics should be published at the commissioner level (ICS or local authority depending on the model). To enforce this, one option is to make using the framework a condition of funding.

To ensure that the burden on providers is reduced, local authorities could be penalised for having overly burdensome data collection processes. This already happens in the education sector, where Ofsted inspectors are instructed to “look unfavourably on schools that implement overly burdensome data collection practices” under the Ofsted Framework. Schools which have 3 or more data drops throughout the year are marked down during their inspections. A similar clause should be introduced under any new commissioning and oversight framework.

Further, local authorities would be mandated to publish ASC expenditure quarterly to allow DHSC to better track funding flows in a timely manner.

Recommendation 2: Turbo-charge digital

None of this can be achieved without improving the digital landscape in ASC and the care workforce’s digital skills.

We would suggest that, first, DHSC would implement a data sharing platform – a central database that consistently pulls the most important information from all relevant actors (local authorities, CCGs, CQC, Skills for Care, etc.) throughout the year. This data should be publicly available as far as possible, to reduce duplication and promote the integration of health and social care.

The platform should drive:

- a “tell us once” system, to reduce burdens on all actors
- a “one stop shop” for researchers, commissioners, government, and providers, and
- encourage innovation by giving access to consistent, standardised, and timely data that ultimately be scraped through machine learning/AI.

Second, we propose the creation of a National Academy for Social Care, an improvement focused HQ for social care (see Chapter 3). This would create learning networks and fund the digital transition for the sector. A nation-wide, time-limited initiative run through this Academy would be aimed at i) getting all providers onto electronic data filing systems, ii) completing the transition to NHS mail (NHSX), and iii) upskilling the care workforce to enable them to use the new digital systems.

Third, part of turbo-charging digital in ASC should include setting a target to move every citizen to electronic health and care records within 2 years. These records would be accessible by everyone who looks after them and either DHSC or the Academy could be responsible for setting common standards across different actors.

Ultimately this 2-step model will help achieve several goals, for example:

- For providers it will reduce the data burden by providing a “tell us once” system, upgrading the technology and upskilling the workforce.
- For local authorities /commissioners it will improve their ability to shape the market and commission more effectively and appropriately by standardising outcomes data and plugging the gaps in the data.
- For national government it will improve their system level oversight and ability to drive the sector by collecting standardised outcomes data and having aggregated timely data. It will also improve their ability to provide oversight to local authority commissioning processes due to readily available outcomes data. Lastly, it will improve their ability to track where the money is going by mandating that local authorities publish this data for social care.

For everyone it will improve access to good quality standardised data, which will allow for spotting trends and innovating.

Table two

What data DH needs	What the data tells us	What DH can do with it
Standardised outcomes data for every LA	How commissioning is working across regions	Reward good commissioners and punish underperformers
LA spending data	Where/how money is being spent	Track funding and hold LAs accountable
Timely data on care workforce	What are workforce capacity issues across regions	Focused oversight to regions with workforce capacity issues
Timely data on provider fragility	Where there are fragility issues across regions	Protect the continuity of service

Conclusion: Trustworthy Data Depends on Building Trust

It is imperative that the national data framework and new approach to digital are forged hand-in-hand with providers, not foisted upon them as mandatory at the last minute. Without trust, form-filling will not achieve our ambitions. Care England has set out 6 key principles which we strongly recommend should guide the government’s approach to data: these are: Benefit; Neutrality; Trust; Soundness; Standardisation; and Centralisation. It will be vital to ensure that the full diversity of the sector is represented in the data and that the central database is funded by government.

Appendix: DHSC note on Mapping roles across the health and social care sectors

Within each we have tried to capture the diversity of similar, overlapping, regulated or other specialised roles. Some roles may span hospital, community and social care settings; their responsibilities may be more defined by relevant health and social care legislation, such as the Care Act 2014, and by the setting than the role. For example, a healthcare assistant working in a care home may have more similar day-to-day tasks to a care worker, than to a healthcare assistant working in a GP practice.

There are core values, tasks and responsibilities which are relevant to all staff in the health and care sector, such as duty of care, safeguarding, ensuring health and safety and improving people's wellbeing and quality of life. These haven't been listed in the tables below unless individuals have specific responsibilities as part of these roles (for example carrying out risk assessments).

Regulated professions such as nursing, social work and occupational therapy abide by the standards of competence and conduct which are set out in professional regulation. These set out the required knowledge, skills and behaviours each professional must demonstrate in order to remain fit to practice (for example through revalidation). All health and care professionals should only carry out tasks for which they are deemed competent (through relevant experience and training).

Table three

	Care worker	Health care assistant
Key roles and responsibilities	<ul style="list-style-type: none"> • Help people manage day-to-day activities, including social and physical activities, personal care, mobility and meal times. • May also be referred to /overlap with similar roles: care assistant, support worker, nursing home assistant 	<ul style="list-style-type: none"> • Work under the guidance of qualified healthcare professional in a variety of settings. • Roles and responsibilities vary by setting but can include clinical and non-clinical care and support • May also be referred to/overlap with similar roles: support worker, nursing assistant, nursing auxiliary
Work settings	<ul style="list-style-type: none"> • Care home 	<ul style="list-style-type: none"> • Hospital setting

	<ul style="list-style-type: none"> • Domiciliary care • Similar roles: personal assistants (individual homes); shared lives carers (stay with people in their home or may be in the carers home) 	<ul style="list-style-type: none"> • Community • Care home • Hospice • In individuals' homes
<p>Pay scales</p>	<p>Est. FTE mean annual pay 18/19 data</p> <p>Care worker: £19,500 (LA), £16,200 (independent)</p> <p>Personal assistant: £17,800 (independent only)</p> <p>Mean hourly wages</p> <p>Personal assistant, direct pay mean - £9.27/hr</p> <p>Care worker, independent sector - £8.41/hr</p> <p>Other estimates in the range: £12,500 – £18,000</p>	<p>NHS Band 2 'Agenda for Change' (AfC)</p> <p>£18,005 – £19,337</p> <p>Other estimates in the range: £18,005 – £24,157</p>
<p>Entry requirements</p>	<p>There are no specific entry requirements for the role, individuals may enter through the following routes:</p> <ul style="list-style-type: none"> • Direct entry, with on the job training • Entry through an intermediate (Level 2) apprenticeship 	<p>There are no specific entry requirements for the role, individuals may enter through the following routes:</p> <ul style="list-style-type: none"> • With experience, training and qualifications through care worker roles • Entry through intermediate (Level 2) apprenticeship

	<ul style="list-style-type: none"> • Qualifications can help in applying for jobs (Level 1 Certificate in Health and Social Care; Level 2 Diploma in Care) • All routes usually require some GCSE-level qualifications 	<ul style="list-style-type: none"> • Relevant qualifications to support an application include: Level 2 Certificate in Work Preparation for Health and Social Care; Level 2 Diploma in Health and Social Care; Level 3 National Extended Diploma in Health and Social Care. • All routes usually require some GCSE-level qualifications
<p>Authorised tasks</p>	<p>Personal care</p> <ul style="list-style-type: none"> • Help with washing and dressing • Help with using the toilet • Help with eating • Promoting health nutrition and fluids intake <p>Living support</p> <ul style="list-style-type: none"> • Cook meals • Household tasks, for example. washing clothes and shopping • Shopping or supporting them to shop • Booking and going with people to appointments <p>Activities, mental wellbeing</p>	<p>Personal care</p> <ul style="list-style-type: none"> • Help with washing and dressing • Help with using the toilet • Help with eating • Promoting healthy nutrition and fluids intake <p>Living support</p> <ul style="list-style-type: none"> • Tidy ward or patients' homes <p>Activities, mental wellbeing</p> <ul style="list-style-type: none"> • Provide emotional support and reassurance • Promoting exercise and activity <p>Health care</p> <ul style="list-style-type: none"> • Using equipment to lift and move patients • Performing and recording clinical measurements for

	<ul style="list-style-type: none"> • Activities to support physical and mental wellbeing • Organise or support leisure activities and outings • Emotional or practical support <p>Health care</p> <ul style="list-style-type: none"> • Monitor weight • Record/feedback health concerns • Check they are taking their prescribed medications • Other actions as per service user needs – for example, mobilising to prevent pressure sores; using equipment to lift and move patients 	<ul style="list-style-type: none"> • example, temperature or pulse, and observation • Attend meetings with other healthcare professionals • Check they are taking their prescribed medications <p>In other settings, for example, health centres, may also</p> <ul style="list-style-type: none"> • sterilise equipment • restock consulting rooms • process lab samples • take blood samples • do health promotion or health education work
<p>Tasks with additional training requirements</p>	<p>Dependent Medicine and health</p> <ul style="list-style-type: none"> • Administer medication <p>Staff may undertake training to specialise in specific areas</p> <ul style="list-style-type: none"> • Autism • Learning disability • Supporting people with dementia 	<p>Training</p> <ul style="list-style-type: none"> • Train new healthcare assistants <p>Staff may undertake training to specialise in specific areas for example</p> <ul style="list-style-type: none"> • Palliative care assistants – additional tasks include; apply simple wound dressings, change catheters, cleaning

		and storage of equipment, caring for body after death
New approaches under COVID-19	Providers have identified a need for training in clinical and nursing skills for care staff, including tracheostomy management and basic observational skills to help with GP remote consultations. Care staff are increasingly required to carry out nursing tasks including wound care, injections (for example. for insulin), podiatry and physiotherapy.	

Table four

	Senior Care Worker	Senior healthcare assistants
Key roles and responsibilities	<ul style="list-style-type: none"> • Provide physical and emotional support to individuals • Supervise care workers/assistants • May also be referred to as/overlap with similar roles: Senior care assistant, adult social care support worker 	<ul style="list-style-type: none"> • Clinical and non-clinical healthcare or therapeutic activities, under supervision of registered healthcare practitioner • May also be referred to as senior healthcare support workers
Work settings	<ul style="list-style-type: none"> • Adult care home, client's home • NHS or private hospital 	<ul style="list-style-type: none"> • Hospital, primary, community, health or day-case units.
Pay scales	Est. FTE mean annual pay 18/19 data	In NHS, Band 3 (AfC) £19,737 – £21,142

	<p>Senior care worker: £23,700 (LA), £17,600 (independent)</p> <p>Mean hourly wages</p> <p>Senior care worker: £12.33 (LA), £9.17 (independent)</p> <p>Other estimates: £15,500 – £20,000</p>	
<p>Entry requirements</p>	<ul style="list-style-type: none"> • Direct entry with relevant skills and experience • Through training and promotion • Qualifications for example. Level 3 Diploma in Health and Social Care, Level 4 Diploma in Health and Social Care Management • Advanced (Level 3) apprenticeship, with further training 	<ul style="list-style-type: none"> • Prior experience • Relevant qualifications (for example Level 3 Diploma in Healthcare Support) • Advanced (Level 3) apprenticeship
<p>Authorised tasks</p>	<p>Supervision and management</p> <ul style="list-style-type: none"> • supervise a team of care assistants • keep families up to date about their relative's progress • train and mentor new staff • attend team meetings with service managers 	<p>Supervision and management</p> <ul style="list-style-type: none"> • Supervise or guide less experienced team members <p>Personal and health care, and care planning</p> <ul style="list-style-type: none"> • Undertake a range of physiological measurements on adults

	<ul style="list-style-type: none"> • support manager to run workplace according to standards and legislation • provide emergency cover • work with other professionals to ensure individuals get the support they need 	<ul style="list-style-type: none"> • Assist with tissue viability risk assessments • Assist with caring for wounds • Obtain and test samples and other specimens • Support frailty, end of life care • Contribute to discharge from services • Assist nurses with delegated clinical tasks • Other clinical tasks as determined by local settings, for example, supporting patients to receive medication or non-oral treatments, taking ECGs
	<p>Personal and health care, and care planning</p> <ul style="list-style-type: none"> • write, review and update care plans (dependent on settings and complexity) • monitor patients' vital signs, like blood pressure and heart rate • complete patient medication records • Other care tasks as determined by service user needs and local settings 	<p>Other clinical tasks</p> <ul style="list-style-type: none"> • Monitor and maintain the environment, equipment and resources; perform first line calibration on clinical equipment and manage stock control
	<p>Activities, mental wellbeing</p> <ul style="list-style-type: none"> • develop and lead activities for service users 	<p>Activities, mental wellbeing</p> <ul style="list-style-type: none"> • Promoting health and wellbeing

Tasks with additional training requirements	<p>Staff may undertake training to specialise in specific areas</p> <ul style="list-style-type: none"> • For example, dementia care, stroke management, supporting people with learning disabilities 	
New approaches under COVID-19	<p>Providers have identified a need for training in clinical and nursing skills for care staff, including tracheostomy management and basic observational skills to help with GP remote consultations. Care staff are increasingly required to carry out nursing tasks including wound care, injections (for example, for insulin), podiatry and physiotherapy.</p>	

Table five

	Social Care Nursing Associate	NHS Nursing Associates
Key roles and responsibilities	<ul style="list-style-type: none"> • Nursing associates are registered with NMC • Care for patients, working under the direction of registered nurses, often taking a lead on person centred care • Perform clinical observations and tasks, and assist the Registered Nurse in on-going assessment, planning, management and evaluation of care. <p>There are few nursing associates in social care compared to the NHS, where Health Education England (HEE) is leading a national Nursing Associate programme with a commitment for 7,500 Nursing Associate apprentices to enter training in 2019 to 2020. Social care faces a range of</p>	

	barriers to delivering more NAs which we are providing further advice to you on in the nurse apprenticeship paper.	
Work settings	There are currently small initial numbers, but there is interest in having these roles in a range of social care settings including nursing Homes, community, domiciliary care, learning disability residential and day care, prisons, hospice, etc.	<ul style="list-style-type: none"> • Hospital • Hospice • Community
Pay scales	<p>An estimated salary range of £18,813 – £23,761 for nursing associates may reflect the pay scale in both health and social care sector.</p> <p>Nursing associates in social care are generally apprentices, and are employed directly by social care employers. The NHS banding does not apply to any nursing associates who are employed directly by social care employers.</p>	<p>Trainee rate Band 3 (AfC) : £19,737 – £21,142</p> <p>Qualified rate Band 4 (AfC): £21,892 – £24,157</p>
Entry requirements	<ul style="list-style-type: none"> • To become a registered nursing associate, individuals need to pass an NMC-approved foundation degree, either as part of an higher (Level 5) apprenticeship or through self-funding direct entry to the foundation degree. • Entry requirements for training – minimum GCSE grades A-C or equivalent/Functional Skills Level 2 in English and Maths. Prior experience as healthcare assistant or care worker can demonstrate values and behaviours. 	
Authorised tasks	Core skills are the same across health and social care, but roles are variable and dependent upon settings for example, within a hospital, within a learning disability care setting. Nurse associates should show attitudes and behaviours compatible with the expected values and model of care (for example, Social Care Values, NHS Values). They may work	

	<p>within teams with different clinical and care staff, dependent on the needs of the individual.</p> <p>Nurse associates work under the direction of Registered Nurses and may perform a number of clinical and non-clinical tasks including:</p> <ul style="list-style-type: none"> • setting up drips and taking blood samples • monitoring equipment like electrocardiograms (ECGs) • performing and recording clinical observations such as temperature, blood pressure, and pulse • cleaning and dressing wounds • giving injections, certain medications or other complex care as prescribed by the Registered Nurse • sharing information about patients' progress with registered nurses • supporting patients and their families • supporting individuals with all aspects of care including daily living, and promoting health and independence • caring for patients with mental health or learning disabilities • maintaining hygiene standards and managing infection risks • updating patient and work records 	
<p>Tasks with additional training requirements</p>	<p>Staff may undertake training to specialise in specific areas</p> <ul style="list-style-type: none"> • For example, dementia Care, mental health 	<p>Staff may undertake training to specialise in specific areas</p> <ul style="list-style-type: none"> • For example, autism, mental health, or children's nursing
<p>New approaches</p>	<p>There is some anecdotal information about the value of Nursing Associate skills during pandemic, but numbers</p>	

under COVID-19	still very small in social care to have any quantifiable data.
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Table six

	Registered Nurse working in for example. Care Home or home care	Community Nurses (covers the whole range of community-type nursing, including District Nurses)
Key roles and responsibilities	<ul style="list-style-type: none"> • Provide care in care home setting or in individual’s homes • Working in partnership with individuals, families and other professionals to plan care and support • Performing a range of clinical tasks such as taking blood samples or wound dressings • Prevention activities and promoting health and well-being, manage long-term conditions 	<ul style="list-style-type: none"> • Provide care in or close to people’s homes • Also provide outreach services to those who may not have a secure home. • Working in partnership with individuals, families and other professionals to plan care and support. • Performing a range of clinical tasks such as taking blood samples or wound dressings • Prevention activities and promoting health and well-being, manage long-term conditions
Work settings	<ul style="list-style-type: none"> • Usually employed directly by nursing homes or by community providers, including learning disabilities and community mental health services. 	<ul style="list-style-type: none"> • Employed by the NHS to provide care in the community, including primary care settings, care homes and clinics.
Pay scales	<p>Mean annual salary FTE 18/19 £30,400 in the independent sector.</p> <p>NB: This is slightly higher than NHS band 5 (£24,907 to £30,615) at which newly qualified nurses start in</p>	<p>Mean annual salary FTE 18/19 for NHS band 6 £31,365 to £37,890.</p>

	<p>the NHS, but lower than NHS band 6 (£31,365 to £37,890).</p>	
<p>Entry requirements</p>	<ul style="list-style-type: none"> • To qualify as a Registered Nurse, individuals must do either: • Degree in nursing (3 years) – students select one of 4 nursing specialisms: adults, children, mental health or learning disability • Nursing degree (Level 6) Apprenticeship (4 years) 	
<p>Authorised tasks</p>	<ul style="list-style-type: none"> • Clinical tasks as community nurses • Holistic assessment, evaluation and review of individual health needs • Complex, evidence-based clinical decision making planning and co-ordinating care plans • Working in supported accommodation or secure units for offenders with learning disabilities • Liaising with external stakeholders • Appropriate delegation and supervision of assistant practitioners and care staff • Operational and business management, including in some cases as the Registered Manager. • Leadership and management in a complex environment. 	<ul style="list-style-type: none"> • Take temperatures, blood pressures and pulse rates • Undertake physical examinations • Administer drugs and injections • Community and non-medical prescribing • Clean and dress wounds • Set up drips and blood transfusions • Use medical equipment • Monitor patients' progress • Update patient records and handover information to colleagues at the end of a shift • Work with doctors and other healthcare professionals to decide what care to give • Give advice to patients and their relatives • Working in supported accommodation or secure units

		<p>for offenders with learning disabilities</p> <ul style="list-style-type: none"> • Prevention activities, for example, hospital admission avoidance, promoting health and well-being, and managing long-term and enduring conditions. • Re-ablement • Early discharge. • Recording medical information
Tasks with additional training requirements	<p>Post-qualifying specialisms in specific areas, including:</p> <ul style="list-style-type: none"> • Epilepsy management • Sensory impairment <p>Nurses can move between specialisms after qualifying</p>	<p>Post-qualifying specialisms in specific areas - for example:</p> <ul style="list-style-type: none"> • Cancer care • A&E • Substance misuse • Health visitor • Critical care
New approaches under COVID-19	<p>Extended clinical skills for example, verification of death.</p>	<p>Deployment of nurses and other clinical staff to support social care as part of enhanced NHS mutual aid.</p>

Table seven

	Social worker	Allied Health Professionals (AHPs) – for example. Occupational Therapists
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<p>Key roles and responsibilities</p>	<ul style="list-style-type: none"> • Supporting children, families and adults adjust to changes in their lives such as illness, age-related problems, disability, or bereavement. • Intervention where safeguarding concerns. • Legal responsibility for assessing care and support needs under the Care Act, Mental Capacity Act (MCA) Mental Health Act (MHA) and Child Protection. 	<ul style="list-style-type: none"> • Help people overcome difficulties caused by physical or mental illness, disability, accidents or ageing • Focus on prevention and improvement of health and wellbeing to enable independence and quality of life. •
<p>Work settings</p>	<ul style="list-style-type: none"> • Mainly employed in local authority adult services, working with older people, learning/physical disabilities. • NHS, incl. mental health, brain injury and hospital discharge. • Private, voluntary and independent settings, such as substance misuse, end of life/palliative care. 	<p>Varied across:</p> <ul style="list-style-type: none"> • NHS • Social care • Housing • Education • Prisons • Independent and voluntary sector
<p>Pay scales</p>	<p>Mean annual salary 18/19 FTE for social worker with adults £35,600</p>	<p>Occupational Therapist salary £24,907 (newly qualified) -£62,001 (experienced)</p>
<p>Entry requirements</p>	<ul style="list-style-type: none"> • UG - BA Hons Degree • Integrated Degree Apprenticeship • PG – MA in social work or fast-track programmes: 	<ul style="list-style-type: none"> • BA - Degree in Occupational Therapy • MA -PG diploma or MA in Occupational Therapy

	<p>Think Ahead (mental health), Step Up to Social Work, Frontline (child and family)</p>	
<p>Authorised tasks</p>	<ul style="list-style-type: none"> • Understanding an individual’s care and support needs • Undertaking assessments and care planning to help people continue to access the right care • Providing information, advice and counselling • Working with statutory services, for example. police, health, schools and probation. • Intervening when people need support or safeguarding • Keeping records and writing reports, incl. court work. • 	<ul style="list-style-type: none"> • Teach a patient recovering from a stroke how to do things for themselves • Encourage someone with depression to take up a hobby or activity • Suggest ways to adapt an office so that an employee injured in a car accident can return to work • Support patients to manage permanent physical disabilities • Help people with learning disabilities to live independently • Keep notes about clients' progress • Advise and support clients and their families and carers
<p>Tasks with additional training requirements</p>	<ul style="list-style-type: none"> • Approved Mental Health Professionals (AMHP): responsibility for decisions on detention and alternatives to admission under the MHA. • Approved Mental Capacity Professional (AMCP): responsible for assessing need under the MCA where a person may lack capacity. 	

<p>New approaches under COVID-19</p>	<ul style="list-style-type: none">• Temporary registration of 8000 social workers to support local authorities during COVID-19• Redeployment of social workers to support the frontline (which meant no demand for returning social workers).	<ul style="list-style-type: none">• Temporary registration of AHPs as part of Call to Action to support NHS and social care during COVID-19.
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