Good Governance Institute

Homecare Association

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Care England and the Homecare Association

ICS Engagement with the Adult Social Care Sector in Decision-Making

Final Report

May 2022

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We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

Care England, a registered charity, is the largest and most diverse representative body for independent care services in England.

Working on behalf of small, medium and large providers, Care England speaks with a single unified voice for both members and the whole care sector. Its membership includes organisations of varying types and sizes, amongst them single care homes, small local groups, national providers and not-for- profit voluntary organisations and associations. Between them, they provide a variety of services for older people and those with long term conditions, learning disabilities or mental health problems.

Care England is committed to supporting a united, quality conscious, independent sector that offers real choice and value for money. Our aim is to create an environment in which care providers can continue to deliver and develop the high-quality care that communities require and deserve.

The Homecare Association is the UK's membership body for homecare providers, with over 2,400 members nationally. The Association's mission is to work together to ensure that homecare is valued, so that all of us can live well at home and flourish within our communities. The Homecare Association uses its trusted voice to help shape homecare and provides hands-on support and practical tools for its members. All Homecare Association homecare provider members agree to abide by the Association's Code of Practice.

Care England and the Homecare Association

ICS Engagement with the Adult Social Care Sector in Decision-Making

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Executive summary

Following the success of our last report, GGI and Care England are collaborating again to explore how measurement and culture might transform engagement from Integrated Care Systems (ICSs) with the adult social care (ASC) sector. This work also includes the Homecare Association as an additional partner, focusing on care in people's own homes.

In summary, our findings indicate that little has changed since our last report in terms of the overall state of play in the ASC sector. The system change to ICSs presents an opportunity to rectify this, however, not enough is being done currently. We recommend the following is done to address this:

- ICSs note that the social care partner member on the Integrated Care Board (ICB) will not necessarily be able to effectively represent providers, and therefore, ICSs should work with providers to develop more effective engagement mechanisms
- ICSs should develop a plan about how to engage with ASC providers and involve them in the process
- ICSs should have a provider forum or liaise with local care associations which nominate a representative to the ICS Partnership Board
- ICSs should ensure that ASC providers have a role in the new local place arrangements, the Integrated Care Partnership (ICP) and/or the ICB. Perhaps through the creation of paid position that is tasked with furthering the ASC agenda and educating others around them on the issues facing the sector
- The Department of Health and Social Care publish a specific framework for ICS engagement with the ASC sector

We reached these conclusions through a mixture of desktop research, interviews with key figures in the health and sector industry, and a roundtable event, attended by experts in the field.

Introduction

The purpose of an ICS is to deliver properly joined up care, so that people accessing health and care services experience them as seamlessly as possible. It is a partnership between organisations to better meet health and care needs across an area. Despite this, it seems that effective engagement among ICSs with the ASC sector has not been consistent. Recently, much of the focus in healthcare has been more on post-pandemic restoration and recovery, although even that situation still seems to be changing rapidly.

GGI and Care England published the paper, The relationship between the adult social care sector and ICSs: time for action? in May 2021. This report explored the extent to which the ASC sector was being appropriately engaged in the ongoing development of ICSs, and updated our previous joint report, System transformation and care homes, published in 2017.

This report will seek to build upon that work and focus more on how engagement between ICSs and the ASC sector can be improved. We will begin by setting out the context of the issue before presenting the findings of our qualitative research, then delving into more sector-wide issues, namely, the statistics, the future and the role ICSs have to play, as well as the ramifications of the government's October White Paper and how the CQC fit in to this new system. The main body of the report ends with a reference guide for providers that lists all the ICSs by region and the local authorities within them. Followed by our conclusion and recommendations.

To inform this report, GGI held a series of interviews throughout August with ICS leaders and representatives from ASC providers across the country, as well as jointly hosting a virtual roundtable event with Care England and the Homecare Association. Contributors to our research included individuals from the following organisations:

- ICSs:

- Bedfordshire, Luton and Milton Keynes
- Black Country and West Birmingham
- Dorset
- Kent and Medway
- Mid and South Essex
- North East London

- ASC providers:

- Birtley House
- Bluebird Care
- City & County Healthcare
- Four Seasons
- Lodge Group
- National Care Group

Context

This section will outline the current state of play in regards to the development of ICSs and the ASC sector.

As the English population grows and lives longer, demand for ASC services is rising. It has been estimated that as many as 1.7 million more people will require ASC services over the next 15 years.[1]

Currently, those who have under £14,250 in assets do not have to fund their social care, while those with assets under £23,250 will have to partly fund their care. However, this changes under new government plans:

"From October 2023, the government will introduce a new £86,000 cap on the amount anyone in England will need to spend on their personal care over their lifetime. In addition, the upper capital limit (UCL), the point at which people become eligible to receive some financial support from their local authority, will rise to £100,000 from the current £23,250. As a result, people with less than £100,000 of chargeable assets will never contribute more than 20% of these assets per year. The UCL of £100,000 will apply universally, irrespective of the circumstances or setting in which an individual receives care, making it a much more generous offer than a previous proposal in 2015. The lower capital limit (LCL), the threshold below which people will not have to pay anything for their care from their assets will increase to £20,000 from £14,250."[2]

Over the last ten years, demand for local authority funded social care has outpaced growth in funding. Research by the Health Foundation indicates that spending per person on ASC services declined by 12% between 2010-11 and 2018-19.[3] This, in turn, has created inequity within the system as social care providers turn to self-funders to make up the deficit. Moreover, spending on social care per person is lower in England (£324 per person) than in Scotland (£446 per person) and in Wales (£424 per person), with data suggesting that there is regional variation of the hourly paid rate for ASC workers within England too.[4] However, it is important to note that these figures must be placed in the context of the diversity of the sector, as different services cost different amounts and therefore, an average does not necessarily accurately demonstrate how homecare costs differ from residential costs.

Social care is delivered, predominantly, by independent providers who are either commissioned by local authorities or funded by the individuals that use them. 25% of homecare hours are purchased by the NHS. In 2019/20, there were an estimated 18,200 organisations involved in providing or organising ASC.[5] However, as a result of declining funding, higher costs associated with delivering care and worsening recruitment and retention difficulties, many of these providers are handing back contracts to local authorities.

The COVID-19 pandemic has also exacerbated these funding pressures. In October 2020, the Health and Social Care Committee called for a £7 billion annual increase in social care funding to prevent the risk of the sector collapsing.[6] Others, including the Health Foundation, have argued that more will likely be needed. The government has recently announced additional funding for social care of £5.4 billion over three years.[7] This is primarily to fund the changes in the care cost cap and other planned reforms for the sector, and this is still a long way from being adequate to address long-standing issues with the social care sector, including workforce and the way that care is commissioned and purchased. Moreover, not all of this funding is going to social care initially and there are calls from the ASC sector for more to be diverted in that direction this financial year.

Alongside these significant funding pressures, the sector, as with the NHS, is in the midst of a severe workforce challenges. The chief executive of NHS England, Amanda Pritchard, has had to assure NHS leaders that their concerns over capacity within the system were being heard.[8] The social care sector is a significant employer, with around 1.5 million staff involved in delivering social care in England.[9] Recent estimates, however, suggests that there remain as many as 130,000 vacancies in the sector as of 20/21, with a staff turnover rate of 30.8% and 25% of staff employed on zero-hour contracts. It has been estimated that, in order to keep up with demand, the ASC workforce will need to grow by between 650,000 and 950,000 staff by 2035.[10]

Last autumn, the government announced the vaccination as a condition of deployment (VCOD) legislation, which has since been repealed, but would have meant that, from April 2022, all CQC registered providers and as of November 2021, registered care homes, must have had to ensure all staff and any visiting professionals for care homes were fully vaccinated against COVID. This put yet further pressure on care providers both logistically and on the workforce, especially given the levels of suspicion about the vaccine in some areas of society. No doubt the decision to revoke it was partially decided based upon the high numbers of unvaccinated healthcare and domiciliary care workers and the impact their redundancy would have upon the sector.

Historically, ASC services have not been engaged with as effectively as they might have expected to have been in system planning initiatives within Sustainability and Transformation Plans (STPs) and ICSs. Our 2017 report revealed the limited extent to which STPs had involved or reflected upon the ASC sector in their plans. While progress has been made since, there is still a mixed picture across the country and there remains much to do for ASC to be given an equal standing with the NHS.

From our research for this report, it is evident there is a very clear divide in terms of perceptions of the NHS and the ASC sector. This is primarily due to the difference in economic models of the two systems. The NHS can afford to run on deficits and is on the government's balance sheet, and that is reflected in the mentality of politicians and some of the competency levels of those charged with running the system. Overall, we found that very few ICS leaders knew much about social care at all. This is reflected by social care often being treated as an afterthought compared to the rest of the health and social care system.

Emerging themes from our research

From our conversations with ICS representatives and ASC providers, several key themes emerged which highlight the complexity and challenges around ICS and ASC engagement and collaboration. This section will explore these individually.

In particular, those we spoke to highlighted that one of the most challenging aspects in terms of engagement with ASC is that ICSs are still relatively new. ICSs are faced with the challenge to transform into the structure of a statutory board and partnership, while also needing to follow the guidelines and the legislative and regulatory restrictions placed upon them. They need to do all of this while continuing to deal with the ongoing threat of COVID also. From our interviews, many representatives from ICSs seem keen in considering ASC issues and want to achieve more detailed and interactive communications with the sector. However, it is probable that the process will be a slow one. The following issues were consistently mentioned and will be examined in this report:

- **Representation of the ASC sector within ICSs**
- **Workforce**
- **Care service recipients and experiences**
- **Digital innovation in the ASC sector**

Representation of the ASC sector within ICSs

There are currently 42 ICSs in England, many of which differ in size, governance and structure. This results in difficulties for organisations outside of the core group of those involved to have a voice in the new system. Through our interviews with representatives from ASC providers, concerns were raised in regards to local authorities solely representing them at the ICS partnership board level. They feel that each care provider group has a distinct voice that needs to be heard and that many of these board meetings are heavily attended by statutory sectors, which provides a barrier for providers to have an effective input into the conversations.

In our interviews, it was acknowledged that local authorities have historically invested little beyond the amount required in the S75 agreements. This has helped remove barriers in mental health services but not so much in other forms of social care. Bedfordshire, Luton and Milton Keynes (BLMK) ICS are attempting to address this however, by analysing if a reallocation of resources is needed in their commissioning spend. Through collaboration with local authorities and care providers, BLMK are aiming to invest any savings they have back into social care and hopefully reduce hospital admissions as a result.

There do exist examples of good practice, however. In our interviews, the following examples were mentioned that indicate a move in the right direction in terms of ASC representation at ICS level:

- **Developing system leadership for integration, including ASC commissioners and providers, front-line professionals, local communities and local people:**
  - At East Lancashire Hospitals Trust, nurses are being sent into local care homes to provide support and deliver training.
  - BLMK are developing an institute that will deliver care and training across care workers and junior nurses, ensuring there is consistency in the quality of training provided.
- **VCSE integrating into ASC and ICSs, making sure design, delivery, evaluation and connecting with the community is part of the conversation:**
  - The 'North Tyneside Good Neighbours Scheme' was recognised as a good example of this recently, where the local council, charities and the CCG cooperated to provide support to those shielding during lockdown.

Further to this, we were assured there was more dialogue than ever before between ICSs, local authorities, councils, health body representatives, partnership boards and more, about how to bring the ASC agenda to the table. Moving forward, ICSs are tasked to understand the diversity and complexity of the ASC sector better than their predecessors if they want to fulfil the spirit of collaboration that NHS England has planned. A continuation of these conversations will help drive towards that, however, the delay in launching ICSs until July will also likely have an impact. This decision was made primarily as the Health and Social Care Bill is taking longer than expected to pass into legislation.

Workforce

Some of the persisting issues in the ASC sector are employee retention, career progression, staff skills and the quality of training provided to them. These issues have had a grave impact on the sustainability and the quality of service provided in the ASC sector. If this is not dealt with by ICSs as a priority, tens of thousands of vulnerable people could be left without access to the care they need.[12] In fact, ADASS announced a few months ago that 49 local councils are taking measures that will leave vulnerable people isolated or alone for longer periods, due to effect of the Omicron variant on an underfunded sector. The lack of awareness and/or non-existence of career progression and opportunities is a key factor driving social care workers to seek out new roles outside of the care sector.[13] In addition to this, the spring government spending review does not do enough to ameliorate the pressures put on the care sector.[14] While the attraction of new workers is an important cause, it is equally important to improve staff retention rates and help tackle the cyclical nature of the problem. In 2022, we are seeing emerging cost of living pressures and fuel prices also affect staff retention.

In its Integration White Paper, the government outlined proposals to ensure staff working in health and care settings are adequately supported, including ICS involvement in workforce planning and cross-sector training.

During our interviews, the following methods were mentioned as examples of ICSs attempting to tackle these workforce issues in the ASC sector:

- Analysis of pay rates across the health and social care sector
- Exploration of how to provide a clear ladder of career progression
- Ensuring there is consistency in workforce training across care workers, which will also better enable them to move across different care providers
- Investigation of how personal development packages can be provided to staff at place level

These plans, while encouraging, need to be move beyond ideas and into action quickly and substantially in order to adequately deal with the problem at hand. An improvement in the lines of communication between ICSs and the ASC sector would help ensure there is a joined-up effort in this regard and that the plans provide a solution to the actual issues.

We present three examples that ICSs could look at in terms of improving the situations of many ASC workers currently. Firstly, staff recognition, value and reward; secondly, building and enhancing social justice, equality, diversity and inclusion; and thirdly, building upon the NHS People Plan.

- **Staff recognition, value and reward:**

The concept of recognising and rewarding high performing staff is not a new one, however, it is still an invaluable method of improving staff morale and bridging the gap between ASC staff on the front line and those in management. This is especially relevant in regards to ASC workers, who are systematically undervalued. This was partially addressed in May 2021, when the Chief Nurse for Adult Social Care, Professor Deborah Sturdy, announced the launch of a new award to recognise the contribution of frontline workers. The awards consist of a gold and silver variety, and will bring recognition of staff in the ASC sector in line with workforce awards in the NHS.

During our interviews, it was noted that while also being underpaid, ASC workers do not have a standard training programme like their counterparts in the NHS do. This presents issues in terms of career progression and quality of care. In the NHS, if there is a nurse at a particular banding, their level of training is confirmed, however, this is not the same for care workers unfortunately. Professor Sturdy's example of bringing parity of ASC workers in line with the NHS offers a precedent that ICS leaders should recognise and follow, especially in regards to appropriate training.

For the benefit of ASC providers, Skills for Care make the following suggestions that organisations can follow to properly recognise the contribution of their workforce:

- Have an 'employee of the week' or 'month' award
- Enter national recognition and accreditation schemes, such as 'Investors in People'
- Involve your organisation in the Skills for Care 'Accolades Awards' and recognise the achievements of your teams
- Celebrate together – for example, if you get a 'good' or 'outstanding' CQC rating

- Use gift vouchers to reward staff for excellent performance, creative/innovative ideas or for going above and beyond
- Involve the people you support and produce a 'thank you' booklet or share their positive feedback in your workplace newsletter or staff bulletin[16]

In regards to implementing a reward strategy, NHS Employers have published a dedicated webpage to assist ASC providers in doing this. It covers three phases, preparation and planning, development and design, and implementation and communication. It can be found at: www.nhsemployers.org/articles/reward-strategy-toolkit

- **Building and enhancing social justice, equality, diversity and inclusion in the workforce:**

The ASC workforce is a very diverse one, especially in terms of race. Therefore, respect for equality and diversity within the sector must be reflected in the strategies of the organisations within it. In 2013, Skills for Care published their, 'Common core strategic equality and diversity principles', listing the following five as essential for organisations to demonstrate:

1. Commitment to equality, diversity and human rights values
2. Promoting equality, diversity and human rights in decision-making
3. Advancement of equality, diversity and human rights
4. Monitoring equality, diversity and human rights performance
5. Commitment to equal access and open standards[17]

Every care organisation should be able to demonstrate their commitment to these principles to its stakeholders. Furthermore, all employees should be able to understand them and put them into practice. If an organisation feels like it could do better in this regard, there are several strategies available to promoting equality and diversity:

- The development of an equality and diversity policy and ensuring that employees have read and understood the policy
- Providing all staff with the opportunity to complete equality and diversity training as part of their induction
- Providing regular refresher training to reflect changes in legislation
- Promoting individual requirements and developing tailored care plans
- Finding out what service users expect from the services that they are accessing. By keeping their requirements at the forefront of care planning, care can be tailored to always be in the best interests of the service user[18]

Collaboration between ICSs and the ASC sector will help ensure the rights of workers in all corners of the health and social care system are understood and followed by everyone. Parity with the NHS in this area is paramount to the proper integration of ASC workers into the ICS system.

- **People Function:**

In August 2021, NHSE/I published, *Building strong integrated care systems everywhere: guidance on the ICS people function*. The document built upon the ICS Design Framework and the priorities set out in the People Plan. The following ten outcomes-based functions were set out for ICSs to deliver with their partners:

1. Support the health and wellbeing of all staff
2. Grow the workforce for the future and enable adequate workforce supply
3. Support inclusion and belonging for all, and create a great experience for staff
4. Value and support leadership at all levels, and lifelong learning
5. Lead workforce transformation and new ways of working
6. Educate, train and develop people, and manage talent
7. Drive and support broader social and economic development
8. Transform people services and support the people profession
9. Lead coordinated workforce planning using analysis and intelligence
10. Support system design and development[19]

We recommend that there should be an equivalent framework designed for and with the ASC workforce, designed in collaboration with ICSs. This would place ASC workers on an equal footing with their NHS counterparts in this regard and help with their integration into the ICS system.

ICSs could take inspiration from the Regional Partnership Boards in Wales, which are being required to map demand and supply in their regions, including market stability, to determine what is needed in their areas and how demand and supply match up. This data could then be used to better inform workforce strategies. ICSs could take more of a lead in thinking about demand, supply and workforce planning in their regions. However, their approach should be a consistent one and avoid as much variation as possible between different ICSs. Peer-to-peer evaluation and the sharing of best practice, as well as sharing evidencing performance and giving oversight is far easier if this is the case. That, combined with better engagement with the ASC sector, could help ensure there is a suitable allocation of resources for a sector of the health and social care industry that, as previously mentioned, is significantly underfunded and faces a severe sustainability threat if that trend continues.

Care service recipients and experiences

There has been major instability in the ASC sector in recent times and with constant concerns over funding, many organisations are going out of business. In addition, as the English population grows in size and lives longer, demand continues to increase and put more pressure on the limited supply of ASC services. Michael King, Local Government and Social Care Ombudsman, has stated that the sector is "progressively failing to deliver for those who need it most", and that there has been a rise in the rate of failings.[20]

Individuals that we spoke to for this report say they are analysing how to build up capacity in the ASC sector to adequately deal with the continuing demand on the system. To assist ICSs with meeting Care Act Duties, they suggested the below:

- ICSs need to hold themselves to account for residents who are not living within their geographical boundaries and ensure service users are heard in their commissioning plans
- There needs to be more focus on the type of services being delivered, how this encourages aging well and independence, hopefully resulting in a knock-on effect in reducing demand
- More discussions are needed around organisational budgets and personal health budgets as a way to improve personal outcomes and control over the care provided
- More work needs to be done with ASC providers on alternatives for when the quality of care falls short for service users

In one interview, the importance of ASC involvement in the planning of care home pathways was cited as the best way of improving the experience of care recipients. Currently, care homes' interactions with hospitals are two-fold. Firstly, through discharge from hospital into admission to the care home, either permanently or temporarily; and secondly, when care home residents become so ill, they need to be admitted into hospital for short periods of time and then return afterwards. They argued that currently, this way of working is prescribed to them and ASC providers must work within these parameters with no opportunity for input on how this process could be improved. ASC providers can contribute much more effectively pre-event, rather than post-event, and the current way of working does not allow this to happen. ICSs must address this and involve the ASC sector in their plans to change.

However, within care homes themselves, ICSs also need to ensure there is the right balance between it being a care home that provides quality of life and a facility that provides clinical support. It was noted in one of our interviews that there was a worry among some ASC providers that care homes risked becoming care hospitals with the increase in acuity levels at each level of the health system in recent years. Similarly, when considering people being supported in their own homes by social care services, where care delivered is also becoming more complex, this must be viewed as a way to support people to live in a way that meets their social, intellectual, emotional, spiritual and other needs and not only in clinical terms.

The questions arising out of our conversations indicate a move in the right direction among ICSs in terms of integration with the ASC sector. Though these queries have been lingering for some time now so one must ask, how bad do things have to get for there to be a substantial change?

Digital innovation in the ASC sector

Social care has received substantial funding towards digital innovation in recent years. For example, NHS Digital rolled out its Social Care Programme in 2016, with £23m being allocated towards projects such as, the development of applications, robotic technology, the 'eRedBag' and remote monitoring technology.[21] The importance of investment into areas such as these was highlighted by a recent government report,

"Where there is targeted national investment in adult social care digital transformation, it should be in people, communities, staff, approaches and outcomes and it must support the longer-term ambition for adult social care funding and reform."[22]

Another source of funding for digital innovation is the Unified Tech Fund, which comprises of £938m worth of funding to NHS providers throughout the financial year 2021 to 2022. This money is broken down into the following areas:

- Frontline digitalisation - £308m
- Shared care records - £50m
- Cyber security infrastructure - £27m
- Cyber security remediation revenue - £3.3m
- Digital productivity - £4m
- Digital pharmacy, optometry, dental, ambulance and community - £6m
- Diagnostics - £235m
- Elective recovery technology - £250m Digital maternity - £52m
- Digitising social care - £8.2m[23]

All of this funding provides substantial opportunities for collaboration between ICSs and the ASC sector. However, examples of this happening still seem few and far between, which is surprising given the amount of money the NHS has invested. ICSs should constantly be looking at ways to innovate and collaborate with the ASC sector to provide digital solutions to help those being supported by services and staff.

One example we could find is Digital Social Care working with ICSs and NHSx on the Digitising Social Care Records (DSCR) Programme. They state the aims of the programme below:

- To improve the quality of care
- To allow transparency and accountability to those supported and their families and friends about how their information is used
- To support individuals to remain independent for longer
- To improve the quality and efficiency of information sharing between health and social care[24]

There is also the DSCR ICS accelerators, which supports ICSs to deliver in-year projects to support care providers in their local systems to buy and implement digital social care records that best meet their needs. These 9 ICS accelerator projects are being delivered in partnership with care providers and Local Authorities. NHSX is providing funding of £8.2 million to support the digitisation of social care.13 integrated care systems (ICSs) have received funding of up to £679,500 each.

The funding is to pilot digital social care technology with ICSs to include:

- Infrastructure to improve access to high-speed connectivity and devices for care providers
- Fall prevention technologies that can reduce the frequency and severity of hospital admissions
- Digital Social Care Records (DSCR) to ensure data is captured at the point of care and can be shared between care settings

We also found Addenbrooke's Hospital in Cambridge, which, in order to battle the tide of non-elective admissions into primary care, has started to run virtual wards in care homes rather than automatically admitting people. From our interviews, this example is one many are hoping and/or planning to follow in due course.

Case Study

The Connect Programme – Transforming Care for Older Adults in Essex

The following case study was submitted by Mid and South Essex Health and Care Partnership. It demonstrates an example of successful collaboration between partner organisations to improve the outcomes among their local population.

Overview

The Essex health and care system gives thousands of people great care every day. However, in 2019, system partners came together to address the needs of a growing older population and identified that sometimes people were receiving the wrong kind of support. In order to understand the scale of the challenge, they conducted a system-wide diagnostic, which involved reviewing 340 cases and 2147 beds with 96 practitioners. This identified specific opportunities for the system partners to work better together to deliver improved outcomes for residents. They found:

- An opportunity to improve outcomes for 44% of older people supported by social services.
- 28% of acute hospital admissions could be avoided for older people.
- Only 27% of older people go home from a temporary residential placement.
- An opportunity to improve outcomes and achieve savings of between £21m and £26m per year for the system.

As a result, the system partners initiated the Connect programme to transform care for older adults and ensure they get the best ongoing care in the best setting. Ultimately, the programme has been about health and care partners across Essex moving from working in quite a fragmented way to joining up care and making Essex a great place to grow old. It highlights some of the challenges and opportunities involved in investing in many of the recommendations in this report.

Components of the programme

The programme comprises five interrelated projects, each focussed on achieving better outcomes for older adults in Essex - identified at system-level and delivered at place-level. The projects and their respective targets are as follows:

- **Admission avoidance** - aimed at reducing the number of older people admitted to an acute ward by 11%.
- **Discharge outcomes** - focused on making more independent decisions on discharge from hospital and short-term beds and aimed at discharging 240 more people home rather than to a bed every year.
- **Community hospital bed flow** - aimed at reducing delays and length of stay in community hospitals by 23%.
- **Reablement** - improving capacity and effectiveness of services to ensure that everyone who can benefit from reablement has the opportunity to do so, aiming to enable1240 more people to receive the most effective intermediate care every year.
- **Supporting independence** - improving long-term care assessments and decisions to help 1500 people live more independently every year.

Each of these projects is contributing to the overall goal of the programme by bringing system partners together to join up care for patients and residents through changes to services across the whole pathway.

For example, as part of the work to reduce acute admissions, a new urgent community response team (UCRT) had been set up, providing a single integrated service that responds to people experiencing an acute medical crisis in their own home. Prior to this, Mid and South Essex had three community organisations delivering four rapid response services across the region. Studies at the ED front door showed that 9% of over 65 admissions could have been avoided through the use of the UCRT. However, when ambulance crews were surveyed, 70% weren't aware of the service and from 22,000 calls to 111 over six months, only eight had been referred to the UCRT.

The system has now integrated the service to provide a single urgent community response team, with one head of UCRT across the whole service. A range of changes were introduced, including bringing greater access to specialists who could support people to stay in their own homes; increasing awareness of and trust in the UCRT amongst referrers to the services such as 111 and ambulance services; and streamlining data and providing

dashboards that give a clear view of the performance of the service, challenges, and opportunities. These changes have resulted in referrals increasing by 70%, helping to avoid acute admissions and reduce demand elsewhere in the system.

The 'Connect' approach to change

The above five interrelated projects were underpinned by a set of principles agreed by all system partners and used to drive the success of the programme. Three of these principles and their application are described below:

1. **Evidence-based decisions.** A significant challenge of system working is often getting transparency and visibility of data, and then bringing it to life as management and operational information. The system diagnostic provided a rich evidence base to inform and guide decisions, and a single source of truth which all partners could recognise and use to cut through opinions or debate on what to do and where to focus. This was a key enabler of the whole programme – for example, it meant partners could align around a shared vision with a focus on delivering improved outcomes, agnostic of any system partners' goals. As the work has continued, this use of data has also enabled the system to articulate the system benefit for any change that is made and drive continuous improvement – it is now clearer on its performance and able to pinpoint the areas it needs to address to achieve measurable impact.
2. **Learn, develop, and grow.** In order for the change to be truly sustainable, the system has committed to building skills to drive continuous improvement, such that performance can be maintained and improved in the future. This was achieved through a combined approach of on the job learning and classroom sessions. A 'Connect Academy' was formed, starting with a two-week course for five team members who were seconded to the programme for 12 months. This was followed by coaching and support as they delivered the various programme streams. An 'Academy Lite' was also formed; this provided a half day version which over 30 system leaders attended, supporting a consistent language and approach to change across partners.
3. **Collaborate through partnership working.** Each workstream of the programme has been led by a multi-organisational and functional team, drawing together social work, clinical, and operational skills. While challenging at times, this has ensured the workstreams have benefitted. The teams have built strong relationships which they will support further change going forward. This has been mirrored and supported by a joint steering group, driving the direction of the work, and removing blockers.

Impact of the programme

While delivery of the Connect programme remains ongoing, it has already been making a significant impact and is delivering some of the following tangible benefits:

- 3,600 people per year are achieving better, more independent outcomes.
- Use of the UCRT as an alternative to the acute has increased by 70%.
- Discharge outcomes have introduced early identification and multi-disciplinary working to support a 20% reduction in placements to bedded settings post-discharge from acute.
- Community flow has sustainably reduced length of stay delays in community hospitals by 4.5 days, releasing 24-27 beds of capacity and allowing the closure of a site.
- Supporting independence work has aligned social work teams to PCN footprints, with new ways of working helping 25% of people to be supported more independently.
- New ways of working have been developed with the main reablement provider Essex Cares (ECL), which has provided a 20% reduction in length of stay and a 17% increase in effectiveness, lowering onward demand for care.
- Worth over £20m p.a. benefit to the system.

What's next?

There is always more work to do around integration and system working but system partners see Connect being around for many years to come, and really becoming the blueprint for how future programmes across the system are developed, such as a financial sustainability programme. Furthermore, because Connect has improved the level of skills and capabilities across the system, for example, there is now a much more structured approach to measuring benefits and reviewing actions and improvements that can be applied to other programmes of work.

In addition to the improved outcomes that have been achieved for residents, and the financial benefits it is seeing, the system has proven that it is stronger together as a system rather than as individual organisations.

"The Connect programme has been an excellent example of true system partnership in action. It demonstrates what is possible when health and social care partners are properly enabled to combine forces for the good of residents."

"A strong evidence base and use of data at all levels has really united system partners around a shared vision and enabled us to make informed decisions as a system rather than as individual organisations. Working together to test and iterate changes on this shared agenda has enabled us transform care at the frontline in a way that is sustainable, measurable, and crucially, is helping us to achieve fantastic improvements to the outcomes of older people in Essex who look to us for care, while making the most of our resources across the system."

Professor Michael Thorne, Independent Chair Mid & South Essex Health & Care Partnership

The facts and figures

This section will explore the statistics that demonstrate the extent of the problems in the ASC sector.

The ASC sector continues to experience financial constraint. Although funding has increased over the last year, this does not match the resources needed to meet the increase of demand for care each year. Total expenditure in the year 2019/20 on ASC was £23.3bn, an increase of more than £1bn from the year before. Moreover, despite an increase in the demand for services, total expenditure is only £99m more than the level in 2011/12 (in nominal terms).[26] Which means it is effectively a cut when allowed for inflation.

The Health Foundation published their projections for funding in the health and social care sector in October 2021, taking into account the impact of COVID. In it, they estimate:

- For health care, stabilisation would require average real-terms annual increases of 3.2%, with 3.5% for recovery. This equates to between £63bn and £72bn in additional annual funding in 2030/31 over 2018/19.

- For social care, both the recovery and stabilisation scenarios would mean much higher growth than in recent years. Projections show an additional £8.9bn and £14.4bn is needed in 2030/31 over 2019/20 for the stabilisation and recovery scenarios respectively.

- By 2030/31, up to an extra 488,000 health care staff would be needed to meet demand pressures and recover from the pandemic – the equivalent of a 40% increase in the workforce, double the growth seen in the last decade. Alongside this, up to 627,000 extra social care staff would be needed to improve services and meet need – a 55% growth over the next decade and 4 times greater than the increases of the last ten years.[27]

In London, two out of five (38%) of ASC workers were estimated to be non-British nationals in 2018/19.29 Also London was the only region in England to have had an increased vacancy rate during the period of February 2020 – June 2020, compared to before, with every other region being lower.30 However, since mid-2020, the vacancy rate has increased and is higher in domiciliary care now than before the pandemic. This is due to a complex combination of causes, including Brexit. Moreover, the ramifications of the new migration policy following the UK's exit from the EU can be seen in full effect across the country, not just on the care sector in the capital. The UK's immigration system is now a 'points-based' one, which means most of those migrating to the UK to work will need to secure a job requiring skills and salaries above certain thresholds.

Data also suggests that the south-east and east of England are being hit particularly hard too. In other areas of the country, such as the south west, migration policy is having an indirect detrimental effect on the care workforce. This is because the tourism and hospitality sectors are deliberately targeting recruitment from the care sector, as they are now unable to access workers from the EU, unlike in previous years. Likely as a result of this, care workers were added to the shortage occupation list and made an exception to the skills threshold on a temporary basis, opening in early 2022.

During our interviews, the difficulty for ICSs when attempting to allocate resources fairly across a certain patch was often mentioned. Differing levels of social deprivation mean that some areas require more resources than others, requiring a relative distribution of funding between place. Moreover, across British society and even pre-pandemic, there were alarming levels of unmet need among the most socially deprived. The Health Survey for England 2018 found that two out of five older people living in the most deprived fifth of areas did not receive any help when needed with at least one activity of daily living, such as washing or dressing. This is more than twice the rate of unmet need among those living in the least deprived areas.

It is clear that more research needs to be undertaken as to what is behind these alarming statistics. Focus needs to be on staff terms and conditions and the long-term financial sustainability of the sector. A clearly defined role for, and greater engagement with, the ASC sector in the ICS structure will help enable the care sector to have a bigger say on what is needed to tackle these issues. Working together will reduce 'beggar my neighbour' approaches, which means effectively worsening another organisation's economic position for your own organisation's benefit, to ease workforce issues and enable ASC providers and ICSs to identify joint opportunities for improvement. Funding and culture are the two biggest barriers to integration between health and social care. Funding depends on the government, but culture depends on public perception and the perception from healthcare colleagues.

Moving forward

So, what does the government plan to do to help the ASC sector?

The Department of Health and Social Care Outcome Delivery Plan: 2021 to 2022 was published in July 2021. This document described the steps needed to move forward from Covid-19 with the aim to improve healthcare outcomes via a well-supported workforce, transforming technology, infrastructure and a sustainable ASC system.

For example, NHSX will have a new role of helping to manage increased demand by restoring elective care, working with local teams to transform services via the creation of 'new care home' models. This includes covering areas such as hypertension, cardiovascular disease and mental health. Moreover, support will be given to providers to help implement digital social care records to better inform care workers and equip them with the information they need to fulfil their duties of care.

The Department is working closely with local and national partners to ensure that the transformation of the ASC system is informed by diverse perspectives and those with care sector experience. As part of this, there is a move to commission future research and evaluate certain key areas, such as:

- Value for money of intervention for care users
- Housing research and the impact of staff turnover on care quality
- Productivity
- Provider resilience

Rather worryingly, and similarly to the findings in GGI's last report, there seems to be no specific organisational framework in terms of ASC engagement mentioned in the plan. This does not necessarily mean the government is not engaging with ASC to transform the sector and make improvements. Indeed, it mentions that the NHS is actively engaging with the ASC sector to improve its service in terms of working more closely with local partners. However, it lacks any specificity as to how this is being done. This last point is supported by the CQC's Local System Reviews, which identified good practice in local facilities but the lack of a consistent approach across the country.

ICSs need to look at ASC services as a financial opportunity, as social care is historically cheaper than acute care. There are opportunities to use social care to improve preventative measures that can reduce the need for more costly forms of care. It is also important that needs are properly assessed and the required care is adequately funded, with options discussed with the individual being supported. Inappropriate care arrangements (particularly for complex needs) can lead to problems with hospital discharge, pressures in the social care system and readmissions to NHS acute services. While homecare may be viewed as 'cheaper' than a care home placement, it is important to ensure that any complex needs are properly assessed, planned for and funded. Costs of providing care at home increase with the complexity of need, as they would in other settings. ICSs also need to ensure that commissioning practices and funding support sufficient supply in the social care sector to meet demand to ensure smooth discharge processes and avoid bottlenecks in the system related to capacity issues. The optimal way to tackle this problem would be the rebalancing of NHS, care home and home care budgets, which is partially what the government seem to be targeting with their 'People at the Heart of Care' paper. However, the whole attitude towards the partnership of all three is critical to make that work.

In January 2021, the government also published its response to the Health and Social Care Committee Report on Adult Social Care: Funding and Workforce. In it, the government committed to providing councils with an estimated additional £3bn of support to combat pressures brought about by Covid-19. Moreover, local authorities were granted access to up to £790m of new funding for social care via a 3% ASC precept.33 The most recent Local Government Finance Settlement will also provide £16.3bn funding to local councils. This money is needed to meet increased need from growing numbers of older and disabled people, as well as increases in unit costs from inflationary pressures, such as an increase in the National Minimum Wage by 2023-24.

Though the government has said that its reforms will "fix social care", there remains inadequate funding in the system to do so. ASC sector leaders have expressed concern that workforce shortages will continue, with potentially serious implications for older and disabled people unable to access the care they need. In addition, the risk of insolvency in the provider market is increasing.

The role of ICSs

This section will cover the basic structure of many ICSs and where ASC could possibly fit within them, as well as evaluate the impact ICSs can have on the issues facing the ASC sector.

It is critical that social care has a seat at the table in ICSs from the outset and only this will ensure there is a dramatic improvement in terms of the sustainability of the sector. Inclusion will give ASC a louder voice when establishing guidance and when financial decision-making/resource allocation is discussed. As already stated in this report, ASC is drastically underfunded already and in need of an uptake of investment if it is to deal with the ageing population adequately. A seat at the table will also greatly improve communication between ASC and ICS representatives, hopefully leading to better joined up care closer to home for the populations of the respective ICSs.

In one interview we conducted, it was mentioned how there was some resistance to the concept of ICSs among some NHS trust chief executives. It was noted that if the ICSs work well, the chief executives of NHS providers see a proportion of their authority being eroded in favour of control by the system. However, resistance to a system change that is already a foregone conclusion is ill-advised and these leaders would do better by cooperating with their ICSs through collaboration and engagement with their system partners, including the ASC sector. This would be more likely to garner the power and ability to control the operations of their respective organisations that they desire.

Many ICS leads are in consistent dialogue with representatives from local authorities, who have statutory responsibilities to deliver ASC and have made improvement in the sector a priority. One of the dangers of ICSs talking only to local authorities, however, is that the needs of people paying for their own care are overlooked. Although this may change with the introduction of the new ASC reforms. In addition, local authorities are not the employers of the majority of the 1.5m members of the care workforce and often do not have a detailed appreciation of the operational challenges of delivering care. Whilst the Health and Care Bill lays out aspirations for better integration between health and social care services, without the right people talking with each other, this will remain an aspiration rather than a reality and the views and opinions of local authorities and the NHS are likely to prevail.

In one of our interviews with ASC providers, the changing dynamic between care providers and GPs was also mentioned as a contributing factor to the increased pressure on capacity.

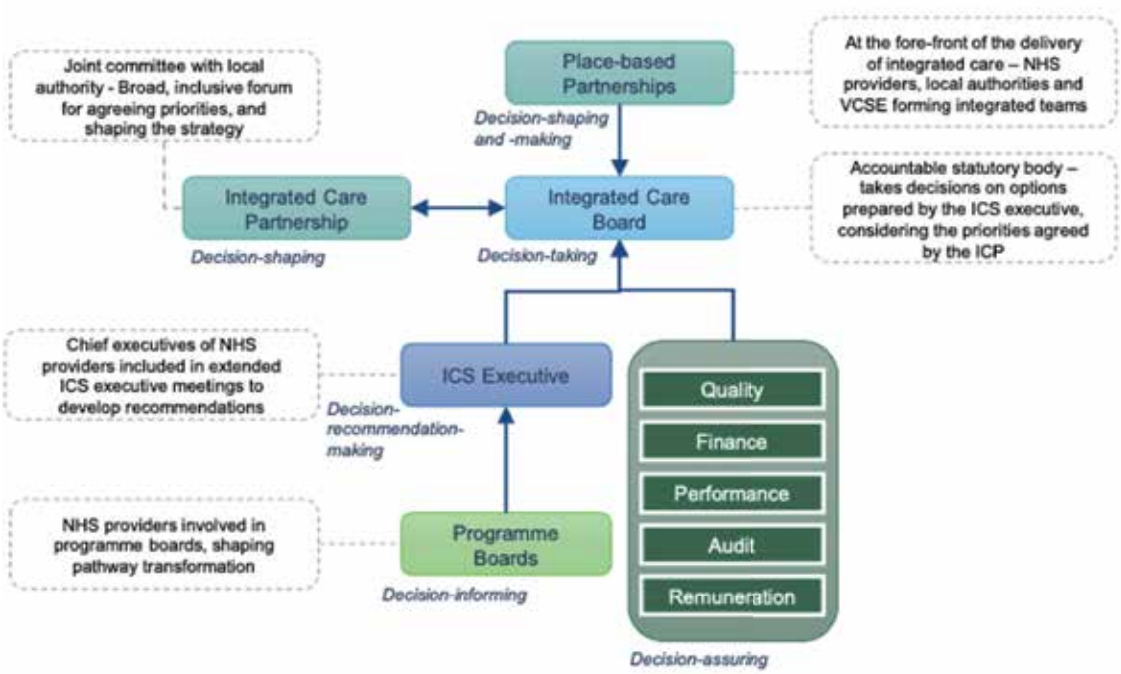
It is still the case that care home residents have to be registered with a GP and historically, GPs would come into care homes to perform their services and in some cases charge for visits. However, recently, there seems to be an increasing reluctance among GPs to take care home residents onto their patient lists, as well as a fall in the number of GPs coming into care homes. ICSs must rectify this and ensure that GPs have an obligation to take care home residents onto their patient lists and make it straightforward to do so, as well as provide face-to-face visits for these patients without charge.

This point further highlights the importance of relationship building between ICSs and their partners. From our research, the Strategic Development Plan (SDP) from Sussex Health and Care Partnership ICS, provided a good example of what ICSs should follow in this regard:

> "We are participating in the national programme to develop the ICS People directorate functions and operating model, and have commenced a review of the capacity and capabilities we will need."[34]

As previously mentioned in our report, there are currently unclear pathways that ASC can use to engage with the key decision-makers on these topics, particularly in regards to place-based arrangements and their influence on system-working.35 We are hoping that greater integration between ASC and ICSs will give clarity on pathway engagement, as well as the roles, responsibilities and the ability for ASC to address these issues.

For the benefit of ASC organisations, an example ICS structure can be seen below, although this can vary by system:[36]



This shows the potential complexity of the ICS structure. ASC would fit into this by having a seat on the Integrated Care Board (ICB) or the Integrated Care Partnership (ICP) or at least a large representation at place level. ICPs are the statutory committee of the ICS, while ICBs and local authorities are statutory members of the ICP and form an equal partnership.

Roles and responsibilities of the ICB[37]

Following our recommendations, ASC would be at least be represented on the ICB and therefore, have the following roles and responsibilities:

- Developing a local population health plan
- Effective allocation of resources
- Establish joint working arrangements with partners
- Establishing governance arrangements to support collective accountability
- Putting contracts and agreements in place to secure delivery of its plan by providers
- Convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes
- Support the development of primary care networks (PCNs)
- Working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people
- Leading system implementation of people priorities
- Leading system-wide action on data and digital
- Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes

- Through joint working, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability
- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability
- Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need
- Functions to be delegated by NHS England and NHS Improvement include commissioning of primary care and appropriate specialised services

Role of ICPs[38]

Following our recommendations, ASC would be at least be represented at ICP level and therefore, have the following roles:

- Develop an 'integrated care strategy' for its whole population (unless the use of the HWB or other strategy is agreed)
- Facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development
- Champion inclusion and transparency
- Challenge all partners to demonstrate progress in reducing inequalities and improving outcomes
- Support place and neighbourhood-level engagement ensuring the system is connected to the needs of every community it includes
- Convene, influence and engage the public and communicate to stakeholders in clear and inclusive language

Defining the purpose and role of place-based partnerships[39]

Place-based partnerships are collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a locality or a community. Following our recommendations, ASC would be at least be represented at place level and therefore, have the following purpose and roles:

- The activities and approaches of the placed-based partnerships within the ICS are supported by an approach to working that embeds systematic involvement of relevant professional groups, service users, carers and communities.
- Partnerships are structured to help constituent organisations to come to effective agreements on where capabilities and programmes should sit to streamline activities.
- Partnerships are able to communicate across the ICS to agree effective delivery at scale, and to contribute to the planning and delivery of system-wide priorities.

Principles of provider collaboratives[40]

Provider collaboratives are partnership arrangements involving at least two NHS trusts, working at scale in multiple places with a shared purpose and decision-making arrangements. For the benefit of ASC organisations that find themselves involved in the ICS structure, below are the principles of provider collaboratives as described by NHS England:

- Shared vision and commitment to collaborate to deliver benefits of scale and mutual aid
- Build on and enable existing successful governance arrangements
- Enable providers to efficiently reach decisions
- Provide strong mechanisms for provider members to hold each other to account
- Make it clear how decisions are made, how disagreements are resolved, how funding flows to services within the collaborative's remit, and how the collaborative is resourced

- Help streamline ways of working within and across systems
- Ensure the needs and voices of local communities are a key consideration in all decisions
- Ensure the needs and voices of local communities are a key consideration in all decisions

Membership of the ICB[41]

Below is the guidance for the membership of the ICB from NHS England. Under our recommendations, a representative from the ASC sector would fill one of the three 'Partner members" positions:

Chair	Appointed by NHS England and NHS Improvement (with Secretary of State approval). The chair must be independent and cannot hold a role in another health and care organisation within the ICB area
NEDs (min. x2)	Appointed by the ICB and are subject to the approval of the chair. These members will normally not hold positions or offices in other health and care organisations within the ICS footprint
Chief Executive	Must be employed by / seconded to the ICB
Chief Finance Officer	Must be employed by / seconded to the ICB
Director of Nursing	Must be employed by / seconded to the ICB
Medical Director	Must be employed by / seconded to the ICB
Partner members (min. x3)	• We expect the partner member(s) from NHS trusts/ foundation trusts will often be the chief executive of their organisation • We expect the member drawn from primary medical services providers to engage and bring perspectives from all primary care providers, including primary care networks • We expect this partner member will often be the chief executive of their organisation or in a relevant executive-level local authority role
All members of the ICB	Each member of the ICB must: • By law be subject to the approval of the Chair (excluding the CEO, who is approved by NHS England and NHS Improvement). • Comply with the criteria of the "fit and proper person test" • Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles). • Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification. • Meet the eligibility criteria set out in the constitution of the ICB

It was noted during our interviews that while a lot of the above information was shared as guidance for ICSs, rather than requirements, there was still a distinct omission of social care providers. The circulation of another round of guidance in this area would both make clearer to ICSs what is expected of them in terms of engagement with care providers and also give the latter adequate representation of a sector filled with independent contractors. However, the representative for the social care sector on the ICB must have a mechanism for taking information from its peers in the sector and reporting it back to the ICB. That individual would be on the board to speak for all care providers, not just the issues in their specific facility. This task would require an especially capable individual and funding from a source that is yet to be identified unfortunately.

One suggestion made during our interviews was to create a paid position within ICSs around care providers and liaison with care providers. The qualification being that the individual is currently involved in a care providing organisation and therefore more than a representative, with a paid position on the partnership board or within the place-based arrangements. This individual could also be charged with educating their peers on the issues at play in the ASC sector and help influence change that way. However, it will be important to include Trade Associations in these discussions, as there is a risk of a potential conflict of interest subject to who funds the role. It would also be equally important that the representative would be able to represent the diversity of the ASC sector, not just care homes.

Promises of new White Papers[42]

This section will cover the government's plans for the ASC sector as set out in their 'People at the Heart of Care' White Paper, released in December.

As well as confirming NHS spending plans and social care funding reform, Downing Street set out several planned reforms in social care, integration, and prevention. There was another White Paper released in February, focused on integration. This other paper seeks to develop models of integration with the NHS, making people's experience of using services more joined up, and other measures like pooled health and care budgets. Some of the key proposals in this paper are summarised below:

- review section 75 of the 2006 Act which underpins pooled budgets, to simplify and update the regulations
- work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling
- develop a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships, subject to the outcomes of the upcoming leadership review
- ensure all professionals have access to a functionally single health and adult social care record for each citizen (by 2024) with work underway to put these in the hands of citizens to view and contribute to
- ensure each ICS will implement a population health platform with care coordination functionality, that uses joined up data to support planning, proactive population health management and precision public health (by 2025)
- enable one million people to be supported by digitally enabled care at home (by 2022
- review barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level
- improve opportunities for cross-sector training and joint roles for adult social care and NHS staff in both regulated and unregulated roles

Building on the principles of the Care Act 2014, the paper talks about listening to people receiving support; personalisation; prevention; choice and control; information to help navigate the health and care system; support for informal carers; support for the professional workforce; innovation and technology; and oversight of the system. However, these aspirations will, however, remain just aspirations unless the vision, plan for implementation, and investment are aligned.

Whilst the proposals contain welcome additional funding for a range of areas, including housing (£300m); innovation (£30m); technology (£150m); informal carers (£25m); workforce (£500m); and testing new ways of providing information (£5m), which will be valued by many, they do not address underlying systemic issues. The government continues to pour billions into the black hole of NHS acute hospitals. There's no sign of a meaningful shift in investment towards supporting people in the community, addressing inequalities or tackling the social determinants of health. While homecare receives only 4% of the amount invested in the NHS.

Demand for home-based support and care is outstripping supply, unmet need is high and rising, and recruitment and retention of care workers in homecare is the hardest it has ever been. Funding cuts to councils over many years have led to rationing and poor approaches to commissioning and purchasing of homecare. In turn, this has resulted in poor pay, terms and conditions for the workforce. Much of the same can be said for workers within care homes also.

The government's answer to this is to say they are putting the Care Quality Commission in charge of oversight of local authorities. It appears, however, that CQC will have no enforcement powers in their role in local authority oversight. All they can do is identify and describe problems, give ratings and write advisory reports. If a local authority is so cash-strapped that it is driven to purchasing social care at fee rates which are too low to enable quality, compliance or sustainability of provision, how will a CQC advisory report change anything?

The ability of providers to charge a fair price for care to self-funders to help maintain solvency is undermined by the policy to encourage further use of section 18 (3) of the Care Act 2014. Simple calculations based on announcements already made suggest that remaining funds available for the fair cost of care are likely to be at least 10 times too low. The Competition and Markets Authority identified that £1 billion extra funding would be needed across the UK for councils to pay fee rates which cover the costs care homes incur.

In the Homecare Association's Homecare Deficit Report 2021, it was calculated that £1.7 billion extra funding would be needed across the UK for public organisations to purchase homecare at fee rates that allow care workers to be paid £11.14 per hour. This is equivalent to an NHS Band 3 healthcare assistant or a supermarket worker. This effectively forces providers to accept local authority fee rates, which will likely remain inadequate due to inadequate central government funding, substantially increasing risk. How does the government expect market stability if investment does not support the policy intention?

Providers are projecting 8-10% increases in costs this coming year, driven largely by wage inflation in the wider economy, beyond the 6.6% increase in the national living wage. Other costs such as National Insurance contributions, insurance and fuel for driving are also rising. Central government has made it clear that councils must cover increases in unit costs and demographic pressures by efficiency savings and increasing council tax. It will not be possible for councils to come close to covering inflationary pressures of 8-10%.

We need to see adequate investment in the social care workforce so they receive appropriate training and supervision as well as fair pay, terms and conditions of employment. The £500m allocated for workforce equates to £111 per person per year. All additional funding is positive but this is not game-changing and the proposals are unlikely to have a significant impact on recruitment and retention. And finally, we need to see better cross-government working to link social care with education, housing, employment, environment, business and the economy, so we can focus more on improving the social determinants of health.

ASC and the CQC

This section will explore the role of the Care Quality Commission (CQC) in improving the relationship between ICSs and the ASC sector.

The role of the CQC is to inspect and regulate ASC services to ensure that the fundamental standards of quality and safety are met. The CQC focuses on outcomes for people who use such services. The information collected is from a wide range of sources, including but not limited to, reports on safeguarding incidents, staffing information, user experience, public and external sources, such as Skills for Care, and Food and Hygiene rating scores. They publish the information together with a rating to guide people in choosing care; and providers are held accountable through regulatory action that can, in extremis, include, prosecution, penalties and de-registration. Equally, the CQC says they help services improve if they have fallen below the acceptable level of care. This is done by giving a warning notice on what improvements need to be made and by when, and working with other organisations to help them make these changes.

In July 2021, the *Health and Care Bill: Adult Social Care Assurance and Support*, introduced a new responsibility for the CQC; to assess commissioners in meeting their ASC duties under the Care Act 2014. The Bill also gave the secretary of state the power to decide to intervene if a commissioning organisation fails to meet its duties to improve. The aim is to enable transparency of operations and to hold commissioners accountable, as well as to ensure that there are sufficient resources to drive high quality care.

However, the CQC has made changes to its inspection processes to take into account the fact that the impact on service user outcomes depends primarily on how services work together, rather than how a specific care provider delivers its service. As a result, the CQC will be working towards strengthening their relationships with service users, providers and partners across ASC and in the future, ICSs. In this regard, ICSs should assume a role in holding commissioners to account when addressing social care issues and help secure improvements in commissioning practices.

The CQC also require quarterly returns about the financial viability from care homes and some non-residential providers too. ICSs could use this information to draw a risk map of care homes that might potentially fail and therefore, gain a better understanding of the relative challenges facing the ASC sector, especially around staff.

The CQC will have the role of reviewing ICSs under the new Health and Care Act, recently consulting on their systems oversight. The Homecare Association responded to this, stating that the way homecare is commissioned and purchased is a major determining factor in the way state-funded care is provided. In turn, this has a significant influence on those receiving and giving care. It is unclear from the evidence that the CQC has used whether they thought about defining what good looks like in terms of commissioning and procurement of care. The CQC has certainly not yet described the latter and does not appear to be proposing to analyse the impact of commissioning and procurement models on outcomes for people receiving services. The care workforce plays a highly significant role in determining the experience of people receiving services and the quality of care. The way they feel they are treated by local authorities and the system more widely is a major influence and this also appears not to feature much in CQC's thinking.

Reference guide for providers

For the benefit of ASC providers, this section includes all of the ICSs and local authorities within the NHS regions of England:

North East and Yorkshire

- **ICSs:**
  - Cumbria and the North East
  - Humber, Coast and Vale
  - North East and North Cumbria
  - South Yorkshire and Bassetlaw
  - West Yorkshire and Harrogate

- **Local Authorities:**
  - Barnsley Borough Council
  - Bradford City Council
  - Calderdale Borough Council
  - City of York Council
  - Cumbria County Council
  - Darlington Borough Council
  - Doncaster Borough Council
  - Durham County Council
  - East Riding of Yorkshire Council
  - Hartlepool Borough Council
  - Hull City Council
  - Gateshead Borough Council
  - Kirklees Borough Council
  - Leeds City Council
  - Lincolnshire County Council
  - Middlesbrough Borough Council
  - Newcastle Upon Tyne City Council
  - North East Lincolnshire Council
  - North Lincolnshire Council
  - North Tyneside Borough Council
  - Northumberland County Council
  - North Yorkshire County Council
  - Redcar and Cleveland Borough Council
  - Rotherham Borough Council
  - Sheffield City Council
  - South Tyneside Borough Council
  - Stockton-on-Tees Borough Council
  - Stoke-on-Trent City Council
  - Sunderland City Council
  - Wakefield City Council

North West

- **ICSs:**
  - Cheshire and Merseyside
  - Greater Manchester
  - Lancashire and South Cumbria

- **Local Authorities:**
  - Blackburn with Darwen Borough Council
  - Blackpool Council
  - Bolton Borough Council
  - Bury Borough Council
  - Cheshire East Council
  - Cheshire West and Chester Council
  - Halton Borough Council
  - Knowsley Borough Council
  - Lancashire County Council
  - Liverpool City Council
  - Manchester City Council
  - Oldham Borough Council
  - Rochdale Borough Council
  - Salford City Council
  - Sefton Borough Council
  - St Helens Borough Council
  - Stockport Borough Council
  - Tameside Borough Council
  - Telford and Wrekin Borough Council
  - Trafford Borough Council
  - Warrington Borough Council
  - Wigan Borough Council
  - Wirral Borough Council

Midlands

- **ICSs:**
  - Birmingham and Solihull
  - Coventry and Warwickshire
  - Derbyshire
  - Herefordshire and Worcestershire
  - Leicester, Leicestershire and Rutland
  - Lincolnshire
  - Northamptonshire
  - Nottingham and Nottinghamshire
  - Shropshire and Telford and Wrekin
  - Staffordshire and Stoke-on-Trent
  - The Black Country

- **Local Authorities:**
  - Birmingham City Council
  - Coventry City Council
  - Derby City Council
  - Derbyshire County Council
  - Dudley Borough Council
  - Herefordshire Council
  - Leicester City Council
  - Leicestershire County Council
  - Milton Keynes Council
  - North Northamptonshire Council
  - Nottingham City Council
  - Nottinghamshire County Council
  - Rutland County Council
  - Sandwell Borough Council
  - Shropshire Council
  - Solihull Borough Council
  - Staffordshire County Council
  - Walsall Borough Council
  - Warwickshire County Council
  - West Northamptonshire Council
  - Wolverhampton City Council
  - Worcestershire County Council

East of England

- **ICSs:**
  - Bedfordshire, Luton and Milton Keynes
  - Cambridgeshire and Peterborough
  - Hertfordshire and West Essex
  - Mid and South Essex
  - Norfolk and Waveney
  - Suffolk and North East Essex

- **Local Authorities:**
  - Bedford Borough Council
  - Cambridgeshire County Council
  - Central Bedfordshire Council
  - Essex County Council
  - Hertfordshire County Council
  - Luton Borough Council
  - Norfolk County Council
  - Peterborough City Council
  - Southampton City Council
  - Southend-on-Sea Borough Council
  - Suffolk County Council
  - Thurrock Council

South West

- **ICSs:**
  - Bath and North East Somerset, Swindon and Wiltshire
  - Bristol, North Somerset and South Gloucestershire
  - Cornwall and the Isles of Scilly
  - Devon
  - Dorset
  - Gloucestershire
  - Somerset

- **Local Authorities:**
  - Bath and North East Somerset Council
  - Bristol City Council
  - Cornwall Council
  - Devon County Council
  - Dorset Council
  - Gloucestershire County Council
  - North Somerset Council
  - Plymouth City Council
  - Somerset County Council
  - South Gloucestershire Council
  - Swindon Borough Council
  - Torbay Council

South East

- **ICSs:**
  - Buckinghamshire, Oxfordshire and Berkshire West
  - Frimley
  - Hampshire and the Isle of Wight
  - Kent and Medway
  - Surrey
  - Sussex

- **Local Authorities:**
  - Bournemouth, Christchurch and Poole Council
  - Bracknell Forest Borough Council
  - Brighton and Hove City Council
  - Buckinghamshire Council
  - East Sussex County Council
  - Hampshire County Council
  - Isle of Wight Council
  - Kent County Council
  - Medway Council
  - Oxfordshire County Council
  - Portsmouth City Council
  - Reading Borough Council
  - Slough Borough Council
  - Surrey County Council
  - West Berkshire Council
  - West Sussex County Council
  - Wiltshire Council
  - Windsor and Maidenhead Borough Council
  - Wokingham Borough Council

London

- **ICSs:**
  - North Central London
  - North East London
  - North West London
  - South East London
  - South West London

- **Local Authorities:**
  - Barking and Dagenham
  - Barnet
  - Bexley
  - Brent
  - Bromley
  - Camden
  - Croydon
  - Ealing
  - Enfield
  - Greenwich
  - Hackney
  - Hammersmith and Fulham
  - Haringey
  - Harrow
  - Havering
  - Hillingdon
  - Hounslow
  - Islington
  - Kensington and Chelsea
  - Kingston upon Thames
  - Lambeth
  - Lewisham
  - Merton
  - Newham
  - Redbridge
  - Richmond upon Thames
  - Southwark
  - Sutton
  - Tower Hamlets
  - Waltham Forest
  - Wandsworth
  - Westminster

Conclusion

Although it is clear that the profile of the ASC sector has grown recently, not least with the publication of the government's plans, there remains a lot to be done. In fact, in some places, the sector continues to teeter on the edge of implosion. Nonetheless, there is an opportunity for ICSs to work with ASC providers and commissioners to develop plans to secure the sustainability of services in their area. Engagement with the ASC sector is very suitable to the spirit of collaboration that the introduction of ICSs is supposedly meant to embody. However, despite this, it looks likely that this opportunity will be missed given the current state of play. Hopefully, this report is a contribution to the drive for ICSs to start to rectify this and begin to develop more effective working relationships with the ASC sector.

Recommendations

It is clear that a stable ASC sector is critical to a good ICS. However, it is also clear that while ICSs should be engaging with the sector and are actually legally required to do so, there are many areas where dialogue needs to be improved. Therefore, GGI, Care England and the Homecare Association, recommend the following to help rectify the situation:

- ICSs note that the social care partner member on the Integrated Care Board (ICB) will not necessarily be able to effectively represent providers, and therefore, ICSs should work with providers to develop more effective engagement mechanisms
- ICS Partnership Boards should develop a plan about how to engage with ASC providers and involve them in the process
- ICSs should have a provider forum or liaise with local care associations which nominates a representative to the ICS Partnership Board
- ICSs should ensure that ASC providers have a role in the new local place arrangements, the Integrated Care Partnership (ICP) and/or the ICB. Perhaps through the creation of paid position that is tasked with furthering the ASC agenda and educating others around them on the issues facing the sector
- The Department of Health and Social Care publish a specific framework for ICS engagement with the ASC sector

Notes

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