Public Policy Projects

Public Policy Institute

The Future of Social Care: Turning Rhetoric into Reality

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CARE ENGLAND

State of the Nation 2021

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Public Policy Projects (PPP) is a global policy institute offering practical analysis and development across a range of sectors, including health and social care. The institute is independent and cross-party, and brings together public and private sector leaders, investors, policymakers and commentators with a common interest in the future of public policy. Chair, Rt Hon Stephen Dorrell and Deputy Chairs, Rt Hon Amber Rudd, Rt Hon Damian Green MP, Baroness Blackwood of North Oxford and Stephen Hammond MP, lead a truly unique policy institute that offers practical analysis and actionable insight around the world. Public Policy Projects publishes annual State of the Nation and State of the Globe reports in a series of policy areas including integrated care, social care, genomics, rare diseases, women's health, AMR, health inequalities, diagnostics, economics, environment and energy, connectivity and 5G, rail infrastructure and planning. All these programmes, and their corresponding events, publications and conferences, receive contributions from sector leaders from around the world.

About Care England

Care England, a registered charity, is the leading 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.
Our 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.

About Anchor Hanover

Anchor Hanover began more than 50 years ago and today is England's largest not-for-profit provider of housing and care for people in later life. It provides retirement housing to rent and to buy, retirement villages and residential care homes, including specialist dementia care. In total, Anchor Hanover serves more than 65,000 residents in 54,000 homes across almost 1,700 locations. Its residential care services employ the majority of the 9,000-strong workforce, providing services to residents at 114 care homes. Anchor Hanover operates in more than 85 per cent of local councils in England.

About LaingBuisson

LaingBuisson has been serving clients for 30 years with insights, data and analysis on market structures, policy and strategy across healthcare and social care. It is the chosen provider of independent sector healthcare market data to the UK Government's Office for National Statistics and works globally with providers, commissioners, payors, manufacturers, investors, regulators and advisors. It helps clients to understand their market, make informed decisions and deliver better outcomes by providing market intelligence, consulting and data solutions.

Foreword: Rt Hon Damian Green

For nearly a quarter of a century successive governments have shied away from a comprehensive solution to the problem of how to fund social care. With the current government looking to finalise its own proposals for the future of the sector, this report from Public Policy Projects (PPP) is both valuable and timely. The recommendations within this document not only offer practical solutions to serious challenges in social care, but put forward a new proposition for the sector.

The devastating effects of the early weeks of the Covid-19 pandemic in care homes brought home to the wider public the urgent need for reform. Vulnerable elderly people were caught up in a fragile support system that failed to protect them. The country needs a '1948 moment' equivalent to the foundation of the NHS: a radical shift which will certainly involve more money but needs to go much further than that.

As well as increased funding, the report stresses that social care must be better integrated with the healthcare ecosystem, linked together with a new digital thread of technology, and an improved infrastructure that will serve to give people more comfort and dignity in later life. These issues overlap in a number of ways, but if the Government wants to find a comprehensive solution it will need to address each and every challenge.

Inevitably, most attention focuses on the funding mechanism needed to address the long-standing problem that we simply do not put enough money in. The best estimate of the current gap in funding for elderly social care is £7 billion and rising. The innovative solution in this report is a variant on the Dilnot solution of a cap on total individual liability. The report proposes a Personal Asset Protection Guarantee, which means that an individual becomes eligible for support once a certain percentage of their assets have been spent. Given that for most people their assets are overwhelmingly their family home, this means the proposals are fair for all parts of the country, despite the massive disparities in house prices between different areas.

Of course, funding is only one part of the solution. The report covers a wider range of contentious issues, including the proper structure for the new integrated care systems, the future of digital care records, and the need for a new planning class for retirement living developments. These attract fewer headlines than the conundrum of how to pay for social care, but they are just as important in providing a sustainable solution.

This is a crucial time for the millions of people who rely on social care in this country. By the end of this year we will know how the Government proposes to transform the system. The recommendations in this report provide a well-researched basis for Ministers to follow, and I hope they adopt many of the ideas which PPP is putting forward.

Rt Hon Damian Green
Deputy Chair, Public Policy Projects

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Introduction

Successive governments have failed to address the crisis in social care, paralysed by the competing claims of fiscal responsibility and the expectations of the electorate. The time is ripe for change in social care. The aim of this report is to help kickstart the reform debate and focus leading minds to come up with solutions that are both realistic and transformative.

The profile of social care was raised in 2018 when the Department of Health was renamed the Department of Health and Social Care. Commentators were split about whether the rebranding would lead to a material difference or was simply 'old wine in a new bottle' Jeremy Hunt, the then Secretary of State for Health and Social Care, was handed the responsibility of producing the promised green paper, and hopes were high for a robust consultation that would lead to real and imaginative change. Since then, our society has changed radically due to the Covid-19 experience. Social care is much more in the public eye and the public are seeking something better: a well-resourced and innovative social care system that is genuinely fit for purpose.

Public Policy Projects (PPP) is pleased to deliver this report at a pivotal point, when many care practitioners are calling for a '1948 moment' to embed social care in the consciousness of the nation. We are starting to take the first steps into a post Covid-19 world, or at least a world in which the threat of Covid-19 might start to diminish. The past year has also shown us that innovative, fast-paced change is possible, and that reforms that would normally take years can, with the right will, happen in months or even weeks.

Social care provision needs to adapt quickly to societal changes and has to flex to deal with the health and care issues people face at any particular time. This report comes after 15 months of lockdown, during which many people have been deprived of the community support that would normally be available to them. As we come out of Covid-19, carers in the community and in residential facilities will be expected to ratchet up their levels of care to help people return to their normal lives.

The report presents a vision of a care system fit for the 21st century. It offers a model of social care in which communities and individuals are empowered to be as independent as they can be within a care system built on solid foundations. It also offers a model of care in which inequalities across the nation are recognised, and local programmes are set up and resourced to mitigate the worst effects of those inequalities.

This report draws on existing literature, pilot programmes, two roundtables and a symposium on international models of care funding where representatives from Japan, Denmark and the Republic of Ireland presented alternative systems of social care. The scope of the report has been directed by the chair, Rt Hon Damian Green MP, who has been tireless in challenging and supporting participants to offer insights on the future of social care and the changes that are needed.

The project was launched at the Conservative Party Conference in spring 2021 with a call for true integration of health and social care and bolstered by the publication a couple of months earlier of the white paper *Integration and innovation: working together to improve health and social care for all.* The participants in the subsequent roundtables came from local authorities, care providers, community innovators, technology companies and users with lived experience of caring. The 22 case studies in this report have been sourced from roundtable

participants, and, in addition, we have invited a wide range of case studies to illustrate the four themes of the report: integration of health and social care, innovation, funding and infrastructure. The compiling and sifting of the evidence could not have been completed without the dedication and co-operation of many people. They include all the roundtable participants, the people who submitted the case studies and the researchers and consultants working with PPP.

Social care is always a work in progress because our social conditions are constantly changing. The proposals put forward in this paper are aimed at setting up a care system that is resilient and adaptable, supported by a funding system based on fairness and equity. Its recommendations have been formulated to feed into the discussion on both the white paper and the plan for social care that is due to be published by the end of this year. When we reconvene next year, let us hope that the discussions we have, and the paper we write, will build on and not simply repeat the reforms proposed here.

Executive Summary

This report, based on the testimony of expert social care practitioners and commentators, focuses on older people's social care in England. It breaks down the issues in social care into four areas:

- Integration of health and social care;
- The need for innovative solutions;
- The funding mechanism; and
- The necessary infrastructure.

There are many overlapping themes between these four areas, which became apparent during the series of roundtables and briefings hosted by PPP in May and June 2021.

Integration: There has never been a more apposite time to discuss integration between health and adult social care. The recently published Department of Health and Social Care (DHSC) white paper, *Integration and innovation: working together to improve health and social care for all*, is a result of a realisation that to improve people's health and quality of life, there needs to be a joined-up service, focused on wellbeing and prevention. The Covid-19 pandemic has exposed the underlying inequalities in England, which are a result of institutional decisions having been made centrally for local areas whose conditions and environment differ. There is a growing realisation that housing is one of the main contributors to health, so the landscape of health must focus more than ever on wellbeing and living conditions.

People should have a choice about where they want to live when they require care and support, and the increased reliance on home care and on people ageing in place is welcomed, as is the recognition of the true value of residential care. Never has public consciousness and approval of the role of social care been higher. This is at a time when there are more than 100,000 vacancies in the social care workforce because of low salaries, increased responsibility and the fact that care workers are often referred to as low-skilled.[1] There is an inbuilt disparity of esteem between the health services and social care, and the white paper risks continuing this disparity due to the lack of balance in the governance structures proposed.

Now is the time to clarify in the public mind the role of social care, and to map out clearly the care options people can choose. We have the opportunity to harness the power of the data collected every day by providers of social care, and there has to be a concerted effort to embed technology and data at the heart of social care provision. Many commentators have claimed that this is a '1948 moment' for social care, whereby its cruciality to societal wellbeing can be embedded into the consciousness of the nation. The Government must legislate for a social care provision and a social care workforce that have parity of esteem with the health services, and whose role in creating a better quality of life is fully recognised.

Innovation: Critical to the capacity for change within the social care system is the adoption of new ways of working based on regional initiatives and working with innovative technologies. Innovation needs to be focused on creating an even playing field for everyone who needs care. There is a need to reimagine the care pathway so that Government avoids simply placing new initiatives into an old system.

Innovation must be judged by the value it creates:

- For the person (the person requiring support and the person or people supporting them); and/or
- for the organisation delivering the care and support; and/or
- for the health and care system as a whole.

There needs to be a culture where regulators and commissioners encourage and reward innovation, and approach it in an ethos of shared endeavour, rather than with caution and suspicion.

Innovative practices must stem from the needs of people and communities. In this vein, PPP supports the work done by organisations such as Think Local Act Personal (TLAP) and the Voluntary Community and Social Enterprise (VCSE) Health and Wellbeing Alliance to include people in decision-making, because change can and should be affected by regional networks.

Technological innovation is fundamental to the development of social care. The starting point in care is that every care provider should have a digital care records management system. This has been recognised by NHSX, whose championing of innovation in social care must be backed by the necessary funding and resources. For technology to be embraced there needs to be a focus on workforce development to ensure that people working in care have a base level of digital literacy that

allows them to work with new technology to benefit the people they are supporting.

While innovation must happen at a local level, it should be supported by national guidelines. These guidelines need to legislate for an effective dialogue between health and care, and for a system where people with lived experience can work with care providers and community organisations to identify innovative solutions.

Funding: Underfunding and inadequately targeted funding are harming our society. A succession of governments have promised reform over the past 25 years, but they have not been able to reach a solution that is backed in Parliament or by the electorate. Even the Dilnot Commission proposals, which received wide support and were enacted in the Care Act 2014, were not actually implemented. At the heart of the issue of funding in social care is inequity: people who need to pay for their care feel they are being disadvantaged because their condition is not deemed to be a health condition, and people who have saved prudently feel that they are disadvantaged in comparison to people who have no assets.

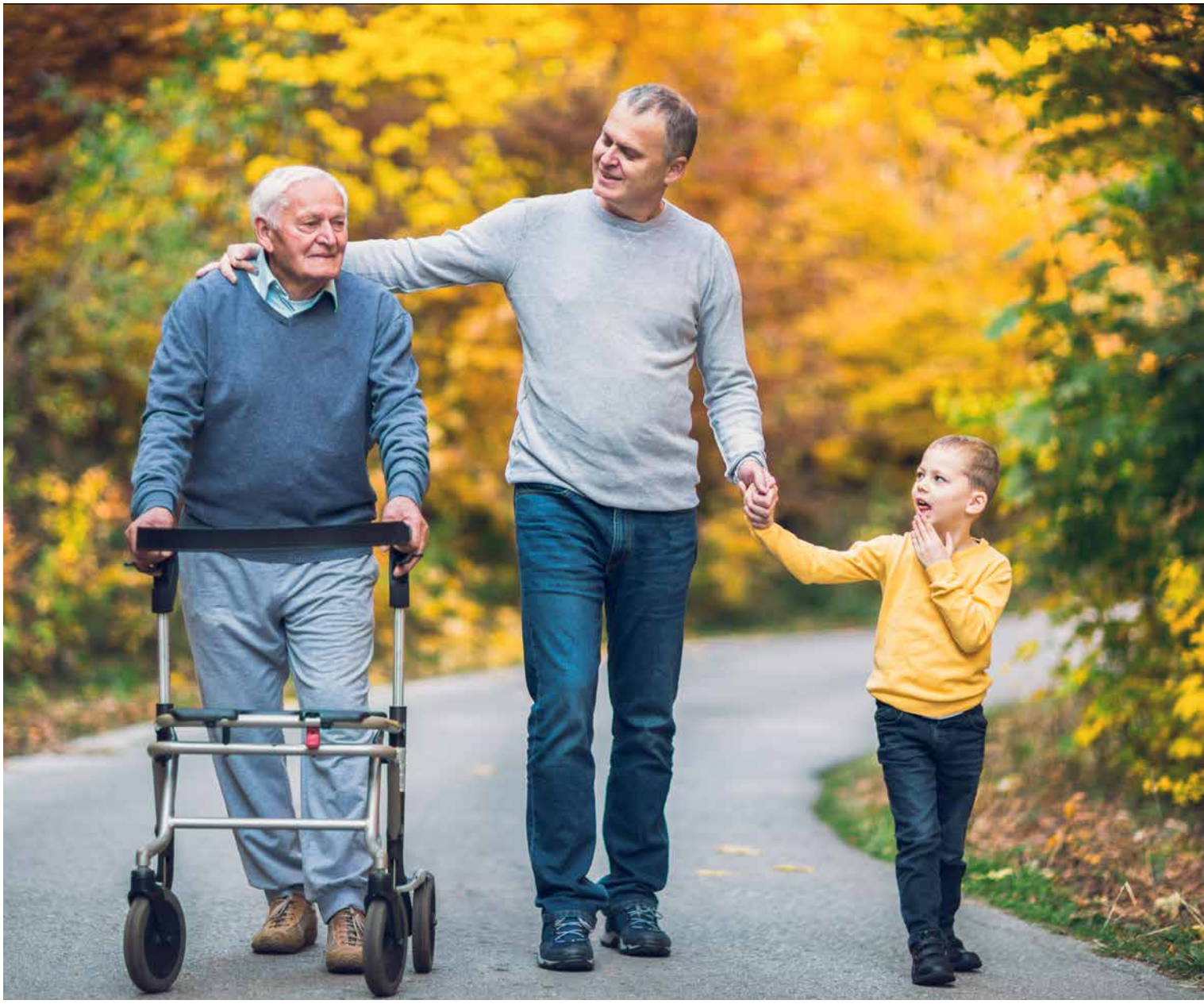
The issue of funding care and support for working age adults must be dealt with separately from that of funding social care for older people. Although there is some overlap between the two, there needs to be a fundamental realisation that care and support for working-age adults should be funded by the state under a separate budget. This paper proposes a funding solution for the care of older people, and the funding of working-age adult care requires its own separate debate.

Any discussion on social care funding has to include discussion of integration. For a health and care system to function there needs to be a shared budget, so that care and health can work as one to create a society focused on wellbeing. It is evident that budgetary integration of health and care would save money, and this issue becomes clearer when considering figures such as the £340 million spent from 2017-2019 on unnecessary hospital bed days as a direct result of lack of funding of social care.[2]

The funding system in countries such as Japan and Germany is based on tax and compulsory insurance schemes: PPP is of the opinion that a compulsory insurance scheme would not work here and so the funding for social care should come from taxation, with people able to enhance the care they receive by using their own assets at their own discretion. This could be in the form of mobilising liquidity tied up in the considerable housing wealth owned by the over-65s, with safeguards in place to ensure they could retain ownership of their property.

The proposed model for state funding is based on the analysis of the Dilnot Commission, but with a different funding mechanism. This is because the Commission's proposals were too complex, had an inherent geographical bias and required constant review of the asset and cap limits. Moreover, their implementation would have rendered the business model of many care providers obsolete by reducing the number of self-funding private payers who are a necessary part of a sustainable business model.

The mechanism proposed is called the Personal Asset Protection (PAP) guarantee: when an individual has spent a certain percentage of their assets, they qualify for local authority support in the ordinary way – provided they meet the eligibility criteria. The local authority will pay for a person's long-term care costs once the person has spent that defined percentage of their assets on care. The modelling in this report is based on a person being eligible for state-funded care when they have spent 30 per cent of their assets on their care. At this level, the total net cost to the taxpayer would be an increase in spending of just over £2 billion per annum, and the asset spend percentage rate could be flexed depending on the will of the Government and on political agreement. The advantages of the PAP system are that it is easy to understand and mitigates some of the inequities inherent in the Dilnot Commission's proposals. This £2 billion is the minimum extra funding required, and many commentators think that the figure of £7-8 billion is a more reasonable figure to re-establish the level of access to state funded services compared with before the financial crisis of 2008, to ensure appropriate remuneration for care staff and embed sustainability in the system.



Infrastructure: For people to choose the care and support they want, they must understand the options they have. There is increasingly a focus on people receiving care in their own residence, and more needs to be done to ensure that legislation on retirement housing and retirement housing with care and support is enacted to clarify its position. There is evidence that retirement housing options are beneficial to a person's health and wellbeing. Over the past 18-months of the Covid-19 pandemic, the need to combat isolation has meant that people have realised the value in this sort of housing where care needs can be easily accommodated. There is great scope for development of this market to serve communities whose care needs are underserved, and legislation needs to catch up with the current provision in terms of consumer protection and in planning. At the same time as realising the benefits of retirement housing with care, there should be a focus on helping people to stay in their own homes, as well as creating a market in individual homes that are built specifically for older people.

The role for care homes in an evolving care market is essential, and their value to society has to be realised. The existing stock of older people's care homes must be brought up to 21st century standards. Moreover, help must be given for the care home sector to recover from the effects of the pandemic. Many care home operators have seen occupancy rates fall and are struggling financially.

For the appropriate infrastructure to be in place, the discussion turns once again to integration as considered in the earlier part of this paper. The decisions on housing and buildings where people can access care have to be taken at a local level to ensure the health and wellbeing of the people living in that area. If the infrastructure needed for health and care services is to be appropriate for the next 20 to 30 years, it is imperative that decisions are made at a local level and are backed by a budget combining health and social care in one.

Recommendations

Integration:

To realise the goal of an integrated system, the Government must:

1. Agree a vision for social care, the so-called 1948 moment for social care, which can lead to a mapped-out system of care opportunities for people.

2. Set strong national guidelines for the governance of care and health that empower a locality to focus on the areas of inequality and poor health in their locality.

3. Set up a housing with care task force working across government to ensure a housing strategy that has healthy living at its core.

4. Act on the October 2020 Social Care Task Force recommendation, which stated that further measures to improve recruitment and retention by mandating each integrated care system (ICS) to have a care recruitment and retention strategy as a core requirement.

5. Legislate for an ICS governance system, which ensures parity between care and health decision-makers by giving the ICS health and care partnership board statutory authority over the decisions of the ICS and ensuring that care, health, housing and population health are fairly represented.

6. Create a national model for data collection, which is based on a single data entry point system at a local level and benefits the people and organisations providing the data.

7. Mandate decision-making bodies in health and care to show how they have involved care providers and people with lived experience in the decision-making process.

8. Revise the commissioning and regulation of care to focus on outcomes rather than outputs.

Innovation:

1. The Care Quality Commission (CQC) needs to create an atmosphere where new forms of innovative care can be commissioned and implemented, not in an atmosphere of fear, but in an atmosphere of supported endeavour.

2. There needs to be a system of online localised care portals, which clearly shows the care journey possibilities and helps guide people through the choices they have.

3. Each ICS should include a social care innovation unit to incentivise and evaluate social care innovations in its footprint.

4. NHSX should be given adequate budget to incentivise the take-up of digital recording systems for all care organisations by September 2022, to ensure that small, medium and large care providers have the resources and expertise to implement digital care records.

5. A social care technology procurement framework taking into account the special needs of social care should be a focus of NHSX's work.

6. Social care providers should be involved even more closely in the development of standards for tech development with NHSX, the PRSB and InterOpen.

7. Digital care records should become the base for a single data platform for care providers to record care information, which can be collated for reporting and analysis by local, regional and national authorities as well as regulators. The aim is to ensure that care providers only have to complete one data platform rather than the many platforms they are currently asked to complete.

8. Adequate funding needs to be given to train the social care workforce via Skills for Care working closely with Digital Social Care.

9. The Government should ensure all new homes are care-ready and designed for digital accessibility to accommodate the changing needs of occupiers over their lifetime.

10. Technology systems collecting data in social care should be mandated to be fully interoperable with NHS data systems.

Funding:

1. There must be some recognition of the fact that there is inequity between the funding of care of people with what are perceived as healthcare issues (e.g. cancer) and those with social care issues (e.g. dementia).

2. A new funding agreement has to be agreed across party political lines and satisfy the needs of commissioners of care, the people who require care and support, and the providers of that care.

3. Funding for care for working-age adults should be from a separate pot and split out from that for older people. It should form the basis of a separate discussion.

4. There has to be greater focus on increasing access to information, sharing funding across health and social care more effectively, and increasing access to respite care.

5. The new system should be based on tax revenue and give people the opportunity to enhance their care environment from their own assets or insurance schemes.

6. The various funding pots should be rolled into one and the system of personal budgets should be enhanced, so people can use the funding available to them to fund the care they want.

7. Various schemes such as equity release and enhanced property rental schemes should be promoted as ways for people to fund enhanced care at their own discretion.

8. There should be a market created for insurance options for long-term care, which would be totally elective, as a way for people to fund the enhanced the care they want to receive.

9. Legislation should be enacted for a new system for regulating the provision of state funding for older people requiring care. The new system should be as simple as possible. The proposal put forward is the Personal Asset Protection (PAP) system. The system would set a percentage of a person's assets, which should be used up before long-term care funding from the state could be accessed. The relative simplicity of the system, and its relative equity to different sectors of society, should mean that it gains acceptability across the major political parties and across a wide spectrum of the electorate.

Infrastructure:

1. Budgets and planning for health and care should be delegated as much as possible so a locality or ICS footprint can design its health and wellbeing infrastructure according to community needs and priorities.

2. There should be a new planning class for retirement living developments that at the moment fall between C3 (normal residential developments) and C2 (developments with a care element). The classifications are outdated and require modernisation. This will have to be co-ordinated with new care regulation relating to retirement communities.

3. The Law Commission findings and recommendations on events fees should be the basis of consumer protection legislation to create more transparency in the market.

4. There should be a government-led programme to help/incentivise people to downsize and/or adapt their home as they grow older. Part of this could be amendment of planning regulation to accommodate the building of more bungalows, which allow people to age better in place.

5. People should be given greater incentives to modify an existing home by increasing the scope of VAT relief on a further range of structural adaptations, which could promote aging well in situ. (There is some suggestion that having left the EU, the UK is now in a position to amend VAT regulations more easily.)

6. Care homes should be incentivised to upgrade services and build new stock as part of the development of the health and care system.

Section 3: Integration

For people who require care to achieve a better quality of life in an integrated system, there needs to be:

- A localised response to national societal inequalities led by robust national guidance and appropriate funding;
- a housing policy that incentivises housing with care options that give people choice for how and where they can access the care they require;
- an enhanced social care workforce that has parity of esteem with their health colleagues;
- a revision of the white paper proposals for ICSs to ensure that an empowered social care provider sector is at the decision-making table;
- a vision for social care that leads to an easy-to-understand mapping of how to access the right care at the right time;
- a co-ordinated data collation and analysis system, which realises benefit for the nation as a whole and for the providers of care;
- a way for people with lived experience of care and delivery of care to be a central part of any system reform; and
- a commissioning system based on the outcomes people achieve.

3.1 Introduction

The key to a better care and health system, focused on the needs of the individual and a preventative agenda, is the true integration of care and health services.

Since March 2020 there has been unprecedented co-ordination and collaboration between health and care organisations. As such, there is a widespread feeling that the time is ripe for this integration to be consolidated with full force. We must not lose the momentum gained from the combined efforts of everyone involved in care and health to get us to this point, where a pragmatic and sustainable model of integration is within reach.

For true integration to take place, there must be a focus on public health and prevention from a local viewpoint. In this section PPP considers the role of housing in expanding the provision of domiciliary care, the impact of better integrated health and care services on the ability of people to age in situ, and the possibility of a more active role for care providers and recipients in the decision-making process. An essential element of these proposals is scrutiny of the structures proposed by the DHSC white paper, Integration and innovation: working together to improve health and social care for all, and the need for a clear vision of social care that is underpinned by data-driven, evidence-based recommendations.[3]

3.2 Public health and prevention: targeted intervention by local agents

The effects of the Covid-19 pandemic have exposed the overall poor public health of the nation and the lack of equality in care and health provision.[4] Forty per cent of avoidable deaths in the UK are due to tobacco, obesity, inactivity and alcohol and other avoidable diseases, and many of the causes of this can be traced back to the £700 million reduction in real terms of the care budget since 2013/14 and 2019/20.[5]

Inequalities have fed the current crisis.[6] To achieve a more equal society, there is a weight of opinion in favour of greater localisation, so that local government can target spending on housing, leisure and other social determinants within a place-based strategy. The rationale is that decisions affecting localities must be made at the local level, by those most aware of the needs within their community.

Local government acts from its base in communities, distinct from NHS structures that traditionally work from a centralised base. An effective social care system will require a structure that allows both the community-focused and centralised approaches to come together to work on improving public health and reducing inequalities in a co-ordinated and integrated way. Achieving this goal will give greater opportunity to avert many people's care and health needs before they become acute. The role for public health, fully immersed in local government in this middle meeting ground, is vital.

The fact that the NHS budget dwarfs the social care budget has led to a skewed system where people are incentivised to fulfil targets, rather than to achieve what is best for the person who needs care in their local situation.[7] A pooled budget for health and social care may be the solution to this issue. There needs to be an understanding that the right decision at the right place at the right level will help the overall health of the nation and reduce the need for intervention, whether it be acute clinical or care in the community.

A preventative agenda is integral to system reform in social care. The delivery of this agenda will be best implemented by clear but permissive national guidelines that allow the local agents of health and care to tailor their services to the needs of their community.

3.2.1 CASE STUDY

London borough of Hillingdon

The London Borough of Hillingdon, together with health partners, has achieved ground-breaking success with the implementation of Discharge to Assess (D2A). The Borough energised a partnership between the NHS, the council and a private care provider that allowed them to focus on the needs of the person requiring support on discharge from hospital.[8]

The issues they faced

In implementing its D2A model, the most pressing issues for the council were ensuring:

- Access to a workforce with requisite skills to support the model;
- sufficient capacity to respond to demand surges;
- the most effective and efficient deployment of the workers across the partners (council, health and independent providers);
- sufficient home care capacity;
- availability of sufficient bed-based care to meet demand; and
- access to short-term care to avoid readmission.

The successful model

Hillingdon has built on good relationships with the local adult social care provider community and with health colleagues, including those in the clinical commissioning groups (CCGs) and the neighbourhood teams/primary care

networks (PCNs). They wanted to create a solution that generated the scale needed while ensuring much-needed care provider financial stability and sustainability.

Three vital elements of the solution were partnership, teamwork and mutual respect.

Hillingdon established an enhanced presence in the hospital discharge team, a unified home care specification and access to packages of care via their brokerage team, irrespective of whether the person was being funded by the council or the NHS. To cope with the demands placed on them by the pandemic, the D2A service was scaled up to lead on the procurement of all nursing home placements. The close partnership between the NHS's continuing healthcare (CHC) team and the council's brokerage team allowed them to overcome difficulties in securing the provision of an improved service for people who required post-hospital care. By working together, the teams could facilitate timely access to placements (including spot purchase and block arrangements), and provide mutual aid at points when the workforce was depleted, to maintain effective discharge planning from hospital and community beds.

Essential elements of the programme

An important component of the success of Hillingdon's solution was its extra care step down provision. During the pandemic, it could mobilise 18 flats in a newly opened scheme to support discharge of Covid-19 positive and negative people from hospital. The 18 flats were reduced to six in June 2020, and it has managed at this level due to enhanced support services. This extra care facility has been an important component of the solution and helped re-enable people to transition to independent living.

Successful collaboration with the care provider market is due, in large part, to the success of the council's quality assurance team (QAT), which had embedded support from the CCG. During the pandemic, this resulted in even closer collaboration between the council and its partners, which has led to:

- Increased resources to the QAT, funded by the Better Care Fund, to allow daily checking calls to care homes and calls three times a week to supported living services. These calls identify issues and reinforce messages such as the importance of updating capacity tracker or issues arising from the latest guidance;
- the identification of a single point of contact in respect of adult social care providers in Hillingdon within the QAT; and
- cross referrals between the NHS care home support service and the QAT, allowing the care home support service to discharge the requirements of the care Direct Enhanced Services (DES) contract.

Hillingdon has achieved its success because of the close relationship formed with the provider market, which has resulted in a mutual support and partnership model. The relationship was further enhanced by the parity of support for care homes supporting people with learning disabilities and/or mental health needs, as well as those supporting older people.

A highlight of this programme has been the addition by the health team of six care home matrons, each with detailed responsibilities for specific

care homes and extra care schemes. These matrons are in daily contact with care providers to give general support and address any clinical issues, so care providers feel supported and are, therefore, more willing to partner effectively.

Other elements that contributed to the success of the programme include:

- A fortnightly care provider forum conference call;
- a weekly newsletter sent to all CQC registered adult social care providers;
- yse of data supplied by Capacity Tracker and the Association of Directors of Adult Social Services (ADASS) market insight tool to identify potential support needs quickly and efficiently; and
- targeted training for providers (e.g. infection prevention and control (IPC) measures).

The success of Hillingdon's approach is based on partnership across the health and care brokerage system, close co-operation with the provider sector, and an ability to commission at scale to support provider financial viability and sustainability. They have created workforce deployment flexibility opportunities and matched the council's assets and resources to the needs of the community.

The D2A service supported 1,811 early discharges in 2019/20 and 1,229 during 2021 to the end of February. Of those people in extra care, 65 per cent of them returned to the community, including people taking tenancies within Hillingdon's extra care schemes.

Partnership has been the key to unlocking this impressive programme, allied with good knowledge of local markets and a forensic approach to challenging the barriers to effective discharge. Partners in Hillingdon have created a seamless pathway out of hospital into the community that provides benefits both for their residents and the system.

3.2.2 CASE STUDY

MHA Staying Well Service South Staffordshire

MHA is a charity in the UK social care sector, founded by members of the Methodist Church in 1943. Today it supports people in its care homes (4,400 people), in its retirement communities (3,000 people) and in its community services (11,100 people) all across the UK.

MHA is part of an integrated system of care around the person, a point exemplified in its South Staffordshire Staying Well Service, a social prescribing service in partnership with the Midlands Partnership Foundation Trust (MPFT). The service was set up at the request of the Chief Executive of the hospital trust, who had been impressed by MHA's previous falls prevention work with people in hospital. MHA was an established partner of this falls prevention service, which helped get people off the ward to exercise and socialise. So, when the hospital wanted to set up a social prescribing service, MHA was the natural partner.

Staying Well is aimed at older people who are moderately frail, do not have high clinical needs and require some preventative measures to ensure their frailty does not escalate. The overall aim is to support these individuals in maintaining their independence for longer. It is a GP referral service and benefits from the one-stop-shop system based at the hospital, where clients can see a consultant GP, pharmacist, memory clinic, occupation health and MHA at the same time. MHA's role is to explore what services could benefit the person in terms of activities, befriending or maybe referral to other services such as Citizens Advice for benefit checks.

MHA is an equal partner with its health colleagues and shapes the direction of the service. The success of the programme has led to an ambition to institute similar services across the whole of Staffordshire and to scale-up across the West Midlands.

The beneficiaries of this service are undoubtedly the people who require further support. The links established between MHA and the health services mean that there is now greater recognition and understanding of the work that MHA, as a social care provider, can do to enhance the quality of life of people who are re-enabled after having required some health intervention.

The Staying Well Service had to stop during Covid-19 because it relied on face-to-face consultation. However, due to its success, MHA became an anchor organisation trusted by the health services to provide for the non-health needs of the clinically extremely vulnerable or any vulnerable person who presented themselves to the health services during Covid-19. Recently the Staying Well Service has resumed and the integrated way of working has been reinforced.

Case study: Mr Salt, aged 95 with long-term health conditions: COPD, atrial fibrillation, macular degeneration: It was identified during the Staying Well clinic that Mr Salt had recently seen a reduction in his mobility, which has led to him becoming socially isolated and reluctant to leave his home without support. Mr Salt agreed to an MHA Communities co-ordinator visiting him at home to complete a needs assessment so that an appropriate support package could be introduced.

In the course of the home visit, it was identified that a number of small household repairs could be completed that would help Mr Salt to remain living independently at home for longer. The MHA handyman completed these tasks within two weeks of the assessment for no charge other than the required materials as pre-agreed.

Mr Salt was also anxious about a number of upcoming hospital appointments that he had to attend alone. MHA Communities arranged for one of its volunteer befrienders to be introduced to accompany Mr Salt. This relationship then continued into a weekly befriending service which meant that Mr Salt no longer felt lonely and isolated and that he remained connected to his local community.

Mr Salt continues to be a member of the scheme and has been supported during the Covid-19 pandemic with telephone befriending and delivery of essentials, such as shopping and prescription collections.

3.2.3 CASE STUDY:

MHA Better Together Befriending Project

The project below describes an integrated approach between MHA (as part of its community services) and Father Hudson's Care (the social care agency of the Catholic Archdiocese of Birmingham) to support people across North Staffordshire through the Better Together Befriending Project. It is a preventative service, enabling older people to maintain their independence for longer.

The two organisations were brought together as a result of lottery funding applications, whereby the Big Lottery Fund identified complementary services in adjacent areas and recognised the potential for working together for greater impact. People who were being supported by one organisation have found increased opportunity to take part in a wider range of activities, and the partnership covers a wider geographical area. By pooling resources, the two organisations have achieved greater impact and offer befriending services to a greater number of people

This matching of complementary organisations is something that would definitely assist the integration of service provision by social care providers.

In October 2020, the project had more than doubled the original number of members to 458 people. The next stage of the partnership is a formal bid to the Big Lottery Fund with another organisation, Beth Johnson Foundation. The project is linked with the Stoke-on-Trent loneliness partnership, a network of voluntary sector organisations, the police, the fire service and other community services, which has helped to strengthen local networks.

The most powerful example of this innovation at a local level is the case study of a man who had recently lost his wife and was struggling with both his mental and physical health. He was not eating properly or taking care of his own personal hygiene. He was hallucinating and was driving under the influence of medication. This was causing him to stop at different parts of his journey to have a sleep. In turn, on waking up he couldn't remember his way home. This meant that what should have been a 25-minute journey resulted in him driving for two-and-a-half hours, until he could retrace his route. He was also taking his wife's ashes with him on every journey and was buying gifts almost daily for her, which he would keep all around the home. He was sleeping in a chair as he had turned his bedroom into a shrine for his late wife and was also convinced that the bathroom belonged to the cat.

In this instance, the Better Together Befriending Project:

- Reported the issue as a safeguarding concern to the local authority team;
- informed his GP, who reviewed the medication and saw that the gentleman needed mental health support;
- informed the mental health team, who had previously worked with the gentleman, but had discharged him, thinking he would be able to cope. The mental health team accepted him as a new referral and allocated him a support worker who could help him work through his daily needs;
- arranged food parcels, a socially distanced garden meeting with him and a regular telephone conversation with a befriender; and
- arranged for a regular telephone befriending call.

These low-level interventions meant that he could live independently in his own home with minimum intervention, thus saving valuable resources for the health services while ensuring his own quality of life.

3.3 Housing and maintaining people in place for longevity and independence

At the centre of an effective social care system is a housing strategy that can form the basis for healthier communities. If the Government puts in place systems to improve houisng provision, then we can start to deal with the care and health issues we face. Meeting the pent-up demand for specialist older people's housing, including retirement housing and extra care, is an essential part of the reforms needed.

A recently published report by the think tank Demos demonstrated the strong relationship between housing and the determinants of health.[9] This is testament to the fact that specialist, planned housing for older people has value for the individual and can lead to cost savings for the care and health system. For instance, there is a strong case that sheltered housing or housing with care, where a person retains their autonomy as much as possible, could save £500 million per annum to the health and care services.[10] However, the monetary value is only one aspect of the value that housing with care (including sheltered housing) can provide.

Anchor Hanover's research, undertaken with Sonnet Advisory & Impact CIC, into the social value of its tenancies, clearly demonstrates the value of supported housing for residents and for public services.[11] The report concludes that a co-ordinated policy will create:

- £2,800 per year per resident social value, in addition to £3,400 delivered for an older person in a general needs social tenancy; and
- savings to the NHS and other public services through tackling loneliness will be

£3,000 per year per resident, and extra care services can save public services £6,700 per year per resident.

An explicit link between housing and care should be a fundamental in any social care reforms. It is proposed that planning system reform should include housing that meets the requirements of all age demographics in regional plans and the creation of a new planning classification for retirement communities. Many social care agencies are prepared to join a Housing with Care task force to work across government to support the development of the sector.[12]

The Commission on the Role of Housing in the Future of Care and Support, launched in October 2020, will look at the social and cost benefits of care homes, retirement communities, retirement housing, supported living and shared lives.[13] PPP supports the proposal that '*Housing with Care*' should become the umbrella term that defines housing choices for older people requiring care. PPP wants the Capital Commission to state strongly that in the formation of the ICSs, there should be a focus on ensuring that people have as much choice as possible about where they receive the care and support they need, be it in their own home or in another place.

It is clear that new models of care must be based on a wider understanding of the potential for new models of *Housing with Care*. Nonetheless, existing models of residential care (for which there is a growing need) have a vital role to play in the housing with care policy.[14] In the care home sector, as in the other areas of *Housing with Care*, there is much need for incentivisation by Government for new builds to replace ageing housing stock. The changing nature of care home provision towards more acute care means that the current care home stock requires a co-ordinated programme to ensure there is a sufficient number of care homes catering for this increased need. The pandemic has seen a wholesale change in the way that people are accessing care from home, so there should be further work to understand how the pandemic has changed people's expectations of how and where they access the care and support they need.

3.4 The adult social care provider perspective

From the point of view of providers of adult social care, the much-needed social care integration with health has been a stalled initiative. However, providers feel that the experiences of the past 18 months have altered the social care landscape. Heightened public awareness of the sector has driven urgency for reform. Research published by Anchor Hanover shows that reform of the social care sector has significant public support:

- 62 per cent of the public have a higher opinion of the social care sector than before the pandemic;
- 84 per cent are demanding parity of esteem between the care sector and the NHS; and
- 54 per cent of the public want to see the Government prioritise reform of social care.[15]

So, the time is now for the Government to put forward its recommendations for the restructuring of care to show that it is listening to what the public want.

To reflect the views of the public expressed above, they Government needs to help build a social care workforce that is professionalised and recognised as such. This needs to be accompanied by the recognition that the social care workforce is as valuable to the country as healthcare workers. There is a clear need for a concerted

campaign to give care workers equal rights and benefits as workers in the health services. This will require a formal social care people plan, similar to that produced for the NHS, with the goal of building a highly skilled, committed and professional workforce for the sector.[16]

This is an urgent initiative. In October 2020, Skills for Care's *State of the adult social care sector and workforce* report estimated that 7.3 per cent of the roles in adult social care were vacant at any one time in 2019/ 20, equivalent to 112,000 vacancies. This figure rises to 12.3 per cent in relation to nurse vacancies in the adult social care sector.[17] PPP's roundtable on the practical infrastructure of integrated care heard from many parties that their staff were disillusioned because of "low salaries, increased responsibility and the fact that every time anyone talked about them, they were referred to as 'low-skilled".

This is at a time when hard-pressed local authorities are tending to refer people to support and care at crisis point. As such, it is even more important that frontline care workers have the skills and experience to support vulnerable people with multiple co-morbidities. In addition to their caring and nursing skills, care staff are expected to show levels of diplomacy, empathy and care that far outstrip the requirements of many other professions.

Some providers are reporting an increased interest in careers in social care as a result of the pandemic, although this is not yet borne out by research. *The Social Care Sector Covid-19 Support Taskforce: final report, advice and recommendations* highlighted the shortfall in workforce numbers and recommended keeping "under review vacancies and absence levels and consider[ing] further measures to improve recruitment and retention if existing strategies do not sufficiently fill the gap".[18] How this recommendation will be implemented remains unclear.

There is much potential for joint working on recruitment and training by health and social care practitioners. Health Education England (HEE) and Skills for Care worked together to develop the Care Certificate and a set of standards applied to those who work across both health and social care.[19] However, the opportunities for real joint training exist in only a few pockets of the country, for example in Shropshire, where the joint training team provides adult health and social care training.[20] There is clear consensus in both sectors that joint working between health and care professionals can develop, if they learn and train together and when multidisciplinary teams on the ground achieve parity of esteem between health and care workers.

3.4.1 CASE STUDY

Anchor Hanover recruitment and retention

Anchor Hanover began more than 50 years ago and today is England's largest not-for-profit provider of housing and care for people in later life. It provides retirement housing to rent and to buy, retirement villages and residential care homes, including specialist dementia care. In total, Anchor Hanover serves more than 65,000 residents in 54,000 homes across almost 1,700 locations. Its residential care services employ the majority of the 9,000-strong workforce, providing services to residents at 114 care homes. Anchor Hanover operates in more than 85 per cent of local councils in England.

There is a misconception that the care sector is low-skilled, low-paid and offers little in the way of career progression.

To counter this misconception Anchor Hanover has developed training and development programmes, to enable staff to enhance their skills and forge a clear career pathway. It has refined its apprenticeship model to offer three sorts of apprenticeships:

- **The apprenticeship programme** for entry-level roles, running over 18 months, helps build necessary skills and experience for a career in care, learning alongside more experienced team members;
- **myRole apprenticeships** for existing staff members who want to learn more about and become more qualified for the role they perform; and
- **myFuture apprenticeships** available to staff looking to train for the next role. An example might be a deputy manager who has been identified as ready to take on the role of a care home manager. By engaging them in the Level 5 Diploma in Leadership and Management for Adult Social Care, Anchor Hanover will enable them to expand their knowledge and prepare for when a vacancy arises.

For colleagues who want to accelerate their development the Anchor Hanover talent management programme – myFuture has been created. It is a leadership programme central to the aim of inspiring experienced colleagues, while offering them the opportunity to progress in the organisation.

The results

There are more than 460 people (i.e. over five per cent of the total staff team) learning through the apprenticeship programmes, representing a growth of 21 per cent from 2020-2021. Seventy-nine staff members have achieved their qualification (since September 2020) and a further 35 are set to complete the programme within the next three months.[21]

Typically, 70 per cent of those who complete the apprenticeship programme secure a permanent role with Anchor Hanover. Of the 100 learners who form the 2020-2021 intake, as at June 2021, 79 remained with the organisation and 29 had already secured a permanent position. All continue to work towards their qualification. The apprenticeship programme helps Anchor Hanover recruit and build a more diverse workforce to help deliver more personalised care going forward. Of the 2020-2021 intake, 17.5 per cent are from ethnically diverse backgrounds and 18.6 per cent have a disability.

Since the introduction of our myFuture talent management programme in 2017, of the 178 starters, 58 per cent (109) completed the programme – of which 62 (34 per cent) have progressed into more senior roles.

3.4.2 CASE STUDY

International social care workforce issues

As presented at PPP's webinar *Social Care: A Global Challenge*.
In the session presenting the care and funding systems in Ireland, Japan and Denmark, all the respective representatives stated that there were difficulties in attracting people to work in social care.

Each of them stated how they are tackling these issues:

Ireland is implementing a workforce plan to enhance career training and progression, increase the renumeration for carers, and improve the terms and conditions under which they are employed.[22] This is especially important because care staff are increasingly being required to look after people with multiple comorbidities and more complex issues. There is also an apprenticeship scheme for school leavers or for anyone interested in becoming a social care worker and a career progression plan right up to management. There is an apprenticeship scheme for school leavers or for anyone interested in becoming a social care worker and a career progression right up to management. There is a move towards decreasing reliance on zero-hours contracts and to more permanent contracts that include pension provision.

Denmark set up a task force in 2019 to consider this issue, and some recommendations were put forward in 2020. It was decided that municipalities were obliged to employ adult students and to ensure they get a salary during the initial basic training and receive further financial support in the early stage of their career. The Government has allocated funds to finance new career pathways for care workers.[23]

In **Japan**, the working age population has decreased by 40 per cent in 30 years, because of the change in the population structure. Compounding the issue is that there is a high turnover rate among the long-term care staff of about 20 per cent per year, and nurses working in health are paid on average 20 per cent more than care workers.[24] Moreover, in urban areas it is easy for people to find better-paid work in roles that are not as complex as those in care. To combat this the Japanese Government has introduced a scheme to increase the wages of care staff, but that is not proving sufficient. As such, there will need to be a focus on improving the working conditions – for example, implementing a better career structure and reducing the burden of working unsociable hours.

3.5 White paper and the ICSs

The DHSC white paper Integration and innovation: working together to improve health and social care for all, hereafter referred to as the white paper, sets out "legislative proposals for a Health and Care Bill … [and] aims to build on the incredible collaborations we have seen through Covid and shape a system that's better able to serve people in a fast-changing world".[25]

While the white paper talks about integration, many of the participants in PPP's roundtable thought that the first stage needed was to embed collaboration in the health and care models of the future. Too much of current thinking is shaped from the point of view of what social care can do to alleviate pressures on the NHS and not how care and health can work collaboratively in a person-centred way. The white paper states that many of the proposals build on the NHS's recommendations in its Long Term Plan, and, although it also claims to focus on social care, there is no commensurate social care long-term plan to give social care the parity required in the modelling.[26]

It outlines plans for a dual integration system whereby there will be integration within the "statutory ICS NHS body" and integration between the NHS and

other bodies in "statutory ICS health and care partnerships". There is concern that the NHS-centric structures proposed will skew any legislation, despite the rhetoric, towards concentrating on inputs and outputs of the NHS rather than the preventative agenda. The paper explains that the dual-board system means that:

> *"The ICS NHS body will be responsible for the day to day running of the ICS, and NHS planning and allocation decisions. It will be responsible for:*
>
> - *developing a plan to address the health needs of the system*
> - *setting out the strategic direction for the system*
> - *explaining the plans for both capital and revenue spending for the NHS bodies in the system"*
>
> *and*
>
> *"The ICS Health and Care Partnership made up of a wider group of organisations than the ICS NHS Body … would be tasked with promoting partnership arrangements, and developing a plan to address the health, social care and public health needs of their system."*

The disparity and power imbalance between the two bodies is clear and means that the proposed legislation risks continuing the power imbalance. If this dual board system is adopted, it might even be a retrograde step for regions where true health and care partnerships exist. There are recommendations, but no clear guidelines, for who should be represented on the ICS health and care partnership.

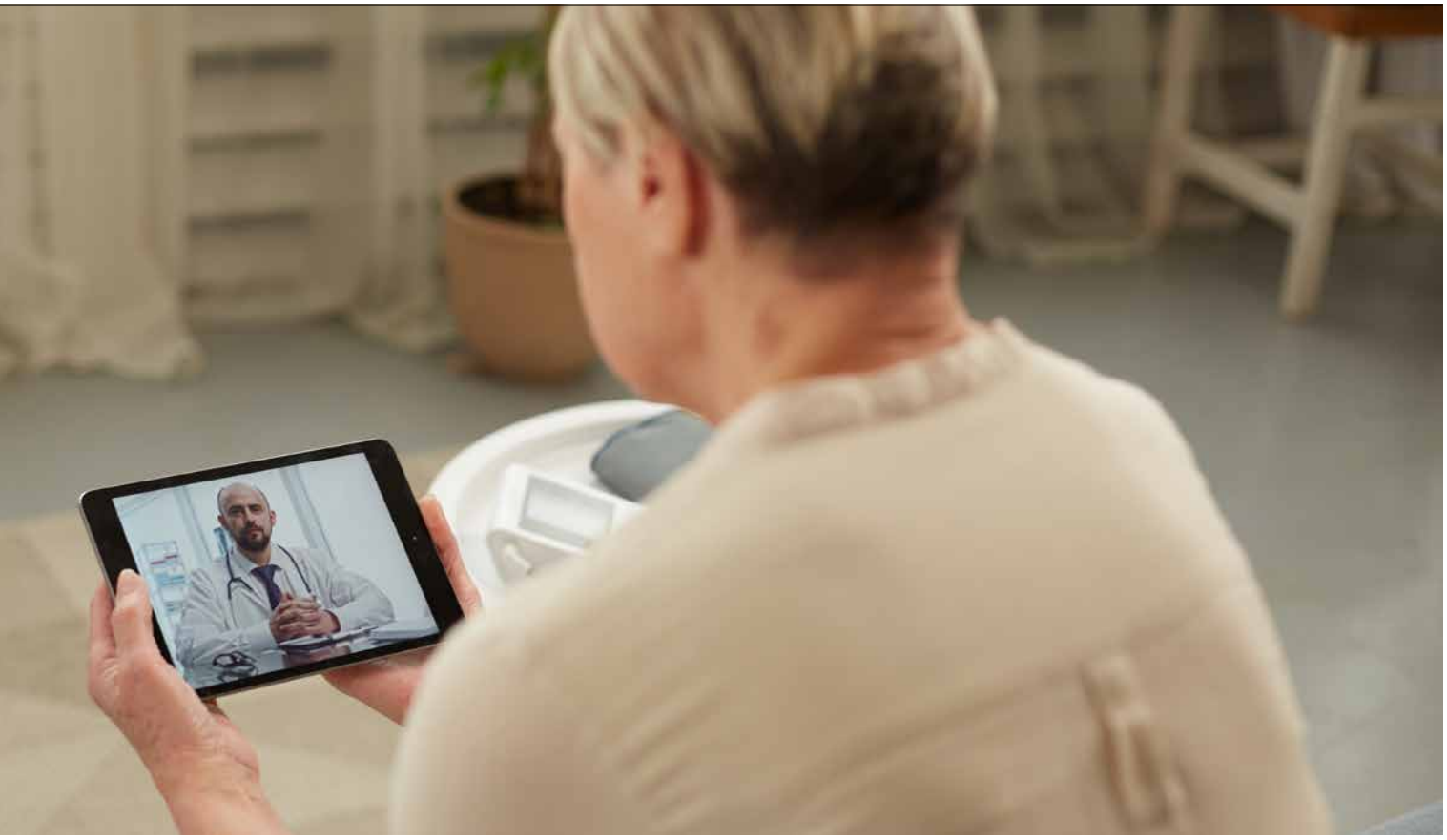
The risk to people who require care is that the housing, public health and care provider bodies will have a minority voice and will not be able to influence policy. These agents must be at the table when strategy and priorities are being set, whereas the proposed structure places them outside the main decision-making body. Moreover, there is no mention of representation for people with lived experience or family carers in the structure, a point that further serves to undermine its validity. Without their full representation, the opportunity for services focused on prevention, rather than acute need, risks being missed.

The recommendations in the white paper seem not to recognise recent integration initiatives and include the creation of new bodies, in spite of the success of the creation of some interesting structures that are starting to work well. One example is the health and wellbeing boards, which have been in place since 2012. Even though they have limited formal powers and the effect of the joint strategic needs assessments they produced is limited, they could be the basis for a truly joined-up system.

The success of the new structure will be judged on whether it allows funds to be directed to where they can have maximum impact. If the changes do not fundamentally change the balance between funding for health and funding for care, the new ways of working could be seen simply as an exercise in time spent on 'rearranging the deckchairs'.

3.6 Vision, mission and mapping

There is public consensus that people working in social care are working with great integrity. However, the lack of direction and clear definition of roles is confusing for the general public.[27] Testimony by people trying to navigate the care system is often unflattering, even if they happen to be involved in health care or related fields. The guidance on the NHS website is good in parts, and while there needs to be full integration so that care and health work towards a seamless integration,



there needs to be a separate identity and branding for social care so that it is clarified in people's minds.[28]

Many people do not understand the possibilities of social care and what it is. In a recent report by Accenture the findings showed that "while more than half (55 per cent) of UK residents surveyed said that the response of their social service agencies to the Covid-19 pandemic has been strong, the majority (92 per cent) said they lack sufficient guidance on what services they are eligible to access".[29] There needs to be a focus on explaining and mapping social care, stemming from a clear vision. In communicating the vision, social care must be characterised as a brand in its own right. A recent survey conducted in March 2021 by the Institute of Health and Social Care Management revealed that the public had a clear level of misunderstanding between healthcare and social care services.[30]

The 'Care' badge was designed independently and handed over to the DHSC in 2020. Since then, it has not been marketed in such a way that it could become an established brand around which people could focus their intent to highlight the needs of the care sector. There are also other initiatives such as the #GreenHeartForSocialCare, which aims to clarify the brand in the public eye.[31] Initiatives such as this, if given sufficient support, could establish the care brand in the eyes of the public and stimulate momentum for real change in social care. The Accenture report stated that "more than one third of the people interviewed for the UK section of the report said they would welcome more proactive information from their social services and welfare agencies about job opportunities and services available to them, and 39 per cent wanted to collaborate to "help co-create new and enhanced services".[32] This is a powerful offer, which should not be spurned.

A clear vision, established branding, and effective mapping of the care options for people would all contribute to a higher profile for social care that would serve to enhance people's understanding of the adult social care system. They should establish the care sector as a core element in the health and wellbeing of the nation: as fundamental as the NHS and health services. While there is some

scepticism that the Government will grasp this, it is a prerequisite to a care service that can be part of a fully integrated system.[33]

3.7 Data and integration

The pandemic has been a wake-up call to all the agents in social care that data is a priority issue. There is general agreement that the lack of data hampered the UK's efforts to control Covid-19 and nowhere was this deficit more acute than in the care sector. [34]

Initially, many local authorities and regional areas enhanced their existing data-collection systems, while the DHSC championed the Capacity Tracker (originally designed as a tool for collating vacancy information on care homes) as the main data source in care. The data collation from the other social care services was initially taken up by the CQC, until it was realised that there needed to be one store of data.

The Capacity Tracker experience is one from which so many lessons can be learned to progress to a data-driven system. It was developed at pace to include all Covid-19-related data and was a top-down exercise, during which many of the major stakeholders providing and receiving the data were not consulted in its initial stages. Its importance was underlined in that it became the mandated gateway to receiving money from the Adult Social Care Infection Control Fund, and it was imposed on care providers at a time when they were dealing with the extra pressures of the Covid-19 situation.[35] It was developed as a system that required manual input and did not tie in with other systems in place, whether they were local authority data collection systems or digital systems used by the care providers. This resulted in many cases in duplication of data entry into different systems that were not speaking to each other. Consequently, there has had to be an attempt to redesign the governance so that:

- The care providers submitting the data have some say in the development of the data source; and
- the issue of open application programming interfaces (APIs) with existing data sources can be explored.

The exercise in setting up Capacity Tracker was central to the urgent realisation that the lack of digitisation in the care sector meant that collation of data was a time-consuming process. It called on the social care providers' resources at a time when staff teams were already stretched. Many care organisations (approximately 50 per cent) were actually using their own digital recording systems, which could have been configured to feed into the central data systems.[36] A pilot programme by NHS Digital to utilise existing data systems to feed into data analysis was set up, and, despite adequate resources, it proved the hypothesis that existing data systems could be used to inform data analysis.[37]

Data will drive improvement in the care sector, and the NHSX programme to incentivise care providers to install digital care records should be applauded as the first step in putting data at the heart of social care provision. This will mean that care providers can record, collate and analyse their own data, and the data that is generated will benefit the care system as a whole. The great work being done by NHSX to promote digital transformation as a route to a data-led system should be backed by sufficient resources to embed this digital way of working in social care.[38]

The whole issue of how digital care records of people receiving care in care homes or at home are incorporated into the shared care record (SCR) must be tackled directly. Where digital records are in place, the ICSs should be encouraged to incorporate the data into the SCR now, in expectation that over the next couple of years all care providers will have moved over to digital care recording.[39]

3.7.1 CASE STUDY

Servelec integrated data record system – Joining-up health and social care

Servelec has created a model for data sharing across health and social care, which creates a joined-up service, saves time and ensures that people who need healthcare services are efficiently transferred between services with full, appropriate information available to the people on whom they are relying. This is a major step forward in creating a fully integrated service.

The Integrated solution combines three components:

- The first is a discharge to assess solution that allows safe, timely hospital discharge where social care involvement is required. Both social care and health practitioners have a single point of truth and are alerted to information changes that may impact on the discharge they are working on. This results in a significant efficiency saving, and less duplication so that decisions can be made more quickly.
- The second component is the social care data service, which is a data standard for sharing the local authority content of a shared care record.
- The third component is the healthcare locator service: a web-based service that NHS trusts can use to identify which local authority is responsible for a person, based on their home address. The service is accurate to the property level, unlike existing tools that allocate all properties in a postcode to a single local authority.

By enabling these transfers of information to happen automatically, the API reduces the number of inappropriate referrals to social care, reducing non-value add activity and improving the person's experience by eliminating the associated process delay.

Nottinghamshire County Council has rolled the products out for use within the local ICS. The acute hospital referrals across three hospital trusts in Nottinghamshire are sent daily to Mosaic from the core hospital systems: this equates to about 10,000 referrals each year. It also receives more than 100 updates on people each day (including when patients move wards), the medically safe status, changes to predicted discharge dates and confirmation of discharges. This has become a business-critical function for the social care teams who support hospital discharges and vital to the support patients and team managers.

In early 2020, one of the wards within Mansfield Community Hospital closed. Many people who were in receipt of social care support moved across the trust to new wards and transferred to other hospitals. The team service adviser reported that this saved her and the involved social workers hours of time because the new location was updated in the hospital bed management system. They were aware of all the new locations and changes to patient status immediately, and there was no delay in chasing information or wasted time calling wards to check people's' locations.

The daily discussions concentrating on medically fit patients mean that the hospitals and social care are working with the same cohort of patients, and they do not need to update manual spreadsheets in social care to prioritise patients. The data now available in the core Mosaic system has been used to build a dashboard, which gives accurate oversight of the staff workload and service pressures. Senior managers use this to look at patterns and trends of

referral numbers. Because the data is automated in Mosaic, the dashboard is updated each evening at the point data warehouses are updated as well.

The care data service is used daily by clinicians across organisations in Nottinghamshire on two different shared record solutions. At Doncaster and Bassetlaw Teaching Hospitals (DBTH), it is used in the in-house developed clinical portal and has been used daily since it went live in November 2019. Since the data was made available in the Nottinghamshire Health and Care portal (a Graphnet Carecentric shared care record) in April 2020, there have been more than 6,000 social care records accessed by more than 1,000 healthcare professionals in local organisations. This ability to access social care provider information can help professionals see where care is in place and contact providers directly, rather than calling Nottinghamshire County Council first. Even the limited data can be enough to speed up decisions on care and support and does not require granting access to external users to Mosaic.

Healthcare staff have fed back that they would like to access this information for other local authorities. Just being able to see if social care is involved is vital in decisions. The usage shows this is accessed on a daily basis (since the initial proof of concept information was available at Kings Mill Hospital) and this shows it is embedded in their daily processes and tasks.

Graphic taken from https://www.youtube.com/embed/8Lb-gUljJ1wY?start=3310&end=4786 at 1:06:14 _ accessed 20 May 2021.

3.7.2 CASE STUDY

Servelec Mosaic Mobilise App

Servelec's Mosaic Mobilise app (developed with Totalise) is a mobile app that allows social workers to access client information and complete assessments on the go. It is the modern face of simple client-focused technology that creates value along the social care workforce.

The app is helping local authorities across the UK to deliver more efficient care services. Social care workers from adult and children services are provided with all the information they need to know about the client via a mobile app linked to the Mosaic database. The app gives social care workers access to the right information at the point of care and the ability to send information to fellow practitioners to review contact information quickly and easily. It makes warning alerts, third-party contacts and any relevant case notes easily available.

The benefits to local authorities, social workers and, most importantly, to the client, are intuitive and proven.

Using Mosaic Mobilise benefits a local authority by:

- Reducing administration as documents can be produced, signed and sent at the point of contact – eliminating the need for repeated journeys to pick up paperwork; and
- social care professionals having access to the most up-to-date and important information at the point of care, in a safe and secure way due to encryption.

Practitioners benefit because it:

- Frees them to focus on the quality of care rather than administration;
- gives better insight into the person and allows them to create a more robust and personalised care plan;
- gives time to focus on the client rather than paperwork;
- allows them to share information appropriately and safely; and
- increases their efficiency.

Most importantly, clients benefit because:

- They get a more efficient, better resourced and interactive service;
- they have more time with the care worker due to the reduced administrative burden; and
- more accurate information means there is a smaller margin for error.

It is a highly scalable solution and could be extended to however many clients the local authority is caring for. It is easy to use because it is device agnostic and allows case notes to be completed at the point of care, consequently they tend to be more accurate. It also allows managers to have real-time updates on caseloads and specific issues. The only constraint to its scalability is the initial upfront cost, although the efficiencies and cost benefits and improvement in work practises are proven.

3.8 Trade bodies and representation of lived experience

If the NHS were to be formed now it would have a very different character, flowing from the community upwards rather than from the centralised bodies downwards. As stated in a recent letter to the Prime Minister signed by 26 co-signatories, there needs to be a "1948 moment" for social care to put prevention at the very heart of care, health and wellbeing.[40] There is also a concern that what is proposed in the forthcoming legislation will actually increase bureaucracy and remove attention further from the person requiring care and support.

If the system is to deliver truly person-centred care, it is important that the structure put in place is based on getting closer to the people providing and receiving care.

One of the main hurdles to integration lies in the fact that both primary and secondary health care are seen as state owned, whereas social care is delivered in the majority by private companies, not-for-profit organisations, community groups and charities. In many cases the role the statutory bodies play is as funders, and true integration can occur only if the non-statutory agents are seen as equal partners, not simply as providers of a service for a fee.

We must be careful not to focus exclusively on the state-funded part of the market. 47 per cent of residents in care homes pay for their own care.[41] For at home care it is very difficult to calculate the number of self-funders due to inadequate data, however, some industry figures put the figure at around 30 per cent which is impossible to corroborate at present.[42] Local authorities have little or no contact with self-funders and so cannot represent them effectively.

In order for the social care voice to be heard there needs to be adequate representation on the decision-making bodies for the care provider voice and for people with lived experience of care, as well as the informal carers and carers employed as PAs on a one-to-one basis. While we realise that this is sometimes difficult, organisations such as the Care Provider Alliance (CPA), Carers UK, Social Care Future and TLAP should be invited to share experience and shape strategy at a fundamental level.[43]

3.9 Conclusion

The integrated systems should be based on outcomes for citizens. The success criteria for these systems should be carefully co-ordinated so that different parts of them are aligned, and the success measures provide a clear incentive for improvement. We need to start aligning the success measures on three bases:

- The first is the experience of the person;
- The second is the outcomes that are achieved (clinical or care based); and
- The third is a measure of the efficient use of resources.

These principles should be embedded as the guiding principles in the commissioning and regulation of social care.

We see a need for even greater focus on localisation, which is guided by strict national guidelines to ensure that the right people are at the decision-making table and not having to seek to influence from a low power position. The

budgetary constraints on social care have hampered the health of the nation and contributed to the poor outcomes seen during the Covid-19 pandemic. The way to confront this issue is by ensuring local health and care plans are coordinated by local bodies on which there is fair representation of people who are giving and receiving care and support.

While retaining existing models of care homes and home care, a further push to create housing options that maximise people's independence and the ability to self-manage their care is needed. This can create value for the person involved, for the organisations and people who provide care, and for the care and health system as a whole. To achieve this, the housing with care sector needs to be incentivised and the benefits of its provision enshrined in the new systems.

One of the major issues that needs to be addressed is the workforce in social care, which has great difficulty in attracting the numbers and calibre of workers needed. The increased awareness of social care and its role in our society should be used as a base to launch a concerted effort to promote caring roles as a career alternative for people who want to make a difference. A major part of this work will be the levelling-up of the working terms and conditions between care and health and increasing the opportunity for joint training and mixed multi-disciplinary teams.

The Government's proposals set out in the white paper are skewed in favour of the health services, rather than the services that combine to improve the overall health and wellbeing of the nation. There is a concern that the dual nature of the governance structure proposed will risk continuing the present power imbalance and not involve the people receiving care and the people giving care. The potential for disparity between the boards recommended in the individual ICSs is too great in the current proposals and so national guidelines must steer the governance structure of the ICSs towards a fairer model where power and influence are shared.

All of these proposals need to be underpinned by a clear vision and mapping of what social care is. This will help to establish the social care brand in the eyes of the public and help people understand the clear, mapped-out pathways and where to find guidance, whether they be supported by statutory funds or making their own independent decisions. This report defines many options to achieve this clear vision, which PPP encourages the Government to explore. The vision must be supported by appropriate data system architecture, which is co-produced with the main protagonists.

Martin Green, Chief Executive of Care England, describes an aspiration where people who need care and support receive a seamless service and have no need of knowing whether they are in receipt of health or social care, because the two brands work as one. He makes the analogy of air travel: in flying to our destination, we cross many boundaries, and all the work to resolve the bureaucratic issues between those boundaries is in the background, while we, the passengers, have an uninterrupted journey to our destination.

We support the call for a "1948 moment" in the health and care system to shape an integrated system where the needs of the people receiving care define the way health and care work. All the elements we have described above can help to define that "1948 moment" for the health and care of the nation.

3.10 Recommendations

To realise the goal of an integrated system, the Government must:

1. Agree a vision for social care, the so-called "1948 moment" for social care, which can lead to a mapped-out system of care opportunities for people.

2. Set strong national guidelines for the governance of care and health that empower a locality to focus on the areas of inequality and poor health in their locality.

3. Set up a Housing with Care task force working across government to ensure a housing strategy which has healthy living at its core.

4. Act on the October 2020 social care task force recommendation, which stated that further measures to improve recruitment and retention by mandating each ICS to have a care recruitment and retention strategy as a core requirement.

5. Legislate for an ICS governance system, which ensures parity between care and health decision-makers by giving the ICS health and care partnership board statutory authority over the decisions of the ICS and ensuring that care, health, housing and population health are fairly represented.

6. Create a national model for data collection based on a single data entry point system at a local level and benefits the people and organisations providing the data.

7. Mandate decision-making bodies in health and care to show how they have involved care providers and people with lived experience in the decision-making process.

8. Revise the commissioning and regulation of care to focus on outcomes rather than outputs.

4: Innovation

There are two main sides to the innovation coin in social care. Firstly, innovative care practices need to be focused on communities, a theme that became clear in the roundtable PPP held on innovation, so that local people can implement local initiatives that stem from the people who require care and support. Secondly, social care needs to be driven by the widespread adoption of digital ways of working to achieve parity with the rest of society.

To drive better quality and greater efficiency in social care, the DHSC is encouraged to foster a sector led by innovation, where innovations are clearly evaluated and valued for the way they effect individuals. The current fixation on the potential for mass roll-out must expand its emphasis to local solutions and local innovations for local people.

The regulatory and statutory systems in social care should enable care providers and commissioners to work together in an atmosphere of supported endeavour, where individuals can access local care portals to guide them in their journey.

This progress should be localised under national guidelines and the resources should be forthcoming to NHSX to promote a technology-first principle in social care. Social care providers should be involved even more closely in the development of standards for tech development.

The aim has to be to ensure that if technology can help social care evolve, then there should be a single platform for data entry so that care providers only have to complete one data platform from which the data can be used for regional and national data analysis.

4.1 Introduction

The roundtable on integration and innovation brought together experts in social care who have been calling for an enhanced infrastructure for innovation in the care sector. There are many pockets of good work where creative and solution-focused innovations are coming to the fore.

The Government's commitment in the 2020 Comprehensive Spending Review to enable councils to access £1 billion for social care was criticised by sector experts as merely reinforcing social care's subordinate position.[44] The adoption of innovative technologies and new ways of working is critical to the capacity of the social care system to streamline service delivery and improve outcomes for people. Money should be set aside specifically to help the sector implement digital social care records (DSCR), which are such a necessary part of the future infrastructure.

Although additional funding was committed to deliver technologies in social care before Covid-19, there is a strong sentiment of this being too little, too late.[45] The lack of technology within social care systems presents a missed opportunity. At a basic level, technology is required to support the work of frontline staff, speed up needs-based assessments and support data sharing between the NHS and social care. The disparities seen in the amount of data from social care and national health bodies throughout the pandemic only serve to add weight to the urgent need for technological innovation.

4.2 The basis for innovation

a. Vision about inequality.

The roundtable participants expressed the desire for innovation to stem from a vision of a social care system that encourages innovative services, incentivises small- and large-scale ideas in innovation, and encompasses low- and hi-tech alternatives. In summarising the thinking on innovation in care, there are many different angles to consider. Should there be national or local initiatives? Should there be a focus on innovation at scale or at a micro level? Should the focus be on directing our attention to people with acute needs or on high impact community innovations that work to bolster the individual as part of community?

At the heart of the thinking in this paper is the desire to create an even playing field for everyone who needs care. The starting point needs to be that we should place equality at the heart of the vision for innovation in social care. .

b. Reimagining rather than replacing.

Innovation should not simply be about replacing the old, rather it should be about reimagining the care pathway shaped by the new digital ways of working interactively between care and health services. During the pandemic, the opinion of those consulted for this report was that many of the advances seen simply consist of digitising the existing pathways, rather than transformative attempts to change the way that people access care and support. Innovation can help us redesign the care pathway and change the whole nature of care and support services.

c. NHSX role and standards and market oversight.

With so much innovation in care concentrating on the new options offered by technology, the efforts of NHSX in joining up care should be commended. The NHSX initiative is paying dividends, and the realisation that a healthy social care function, backed by a technology standards regime will bear fruit should also be commended. Over the course of the pandemic, the work of the Professional Record Standards Body (PRSB) is to be applauded for creating standards that can be widely adopted and accepted across the sector.[46] These create a base for care providers to choose new technology with greater confidence. In addition, there is a record number of care providers publishing the data security and protection toolkit certification, which enables care providers to operate within an environment of integrated health and social care data.[47] This, ultimately, ensures better care focused around a person's wellbeing.

d. Commissioning focused on measures not outcomes.

Innovation must be based on an outcomes approach. At the roundtable, Jane Townson, CEO of the UK Homecare Association (UKHCA), gave the example that most home care providers are paid by the minute for contact time only. In turn, the care workers get paid by the minute for doing tasks pre-determined by social workers. Measurement and performance are based on the time spent rather than improvements in the person's life, so that, at present, the commissioning and funding systems are not aligned with the aspirations of the Health and Care Bill.

e. Value-based innovation.

PPP recommends that evaluation of innovation should be based on a value creation framework. The innovation should be measured on the value it creates directly and indirectly:

- For the person (the person requiring support and the person or people supporting

them); and/or
- for the organisation delivering that care; and/or
- for the health and wellbeing system as a whole.

4.3 Commissioning and regulating for innovation

If innovation in social care is to be incentivised, there must be a commissioning system based on rewarding innovation. Current commissioning practises take into account inputs, such as number of hours per person or global weekly costs. In 2014, the DH (as it was then known), ADASS, the LGA and TLAP produced a document *Commissioning for better outcomes: a route map to aid implementation of the Care Act 2014*.[48] In 2019/20, the NHS specified new guidelines for a commissioning for quality and innovation (CQUIN) framework, which has been republished several times since then, but in reality, its effect in social care has been minimal. Indeed, the latest iteration states that "there will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage".[49]

There is a responsibility to foster an environment where innovation is rewarded and viewed in a positive light. CQC aims to work in a way that encourages technological development and has published *How Technology can support high-quality care,* which states:

> *"Technology is changing the way people provide care and treatment. The benefits can be huge – for people who use services, families, carers and providers. But, it's important technology and innovation never come at the expense of high-quality, person-centred care".*[50]

While the publication is to be applauded, the cautionary way in which it is written, such as in the above passage, means that it disincentivises innovation by introducing the fear factor: it does not welcome innovation with encouragement and appears to give the message 'proceed with caution'. At the PPP roundtable, contributors agreed that the regulatory system is risk-averse, and yet innovation by its nature carries some element of risk. Clearly then, checks and balances need to be put in place that foster creativity and innovation, while taking the risks into account.

CQC needs to create an atmosphere where new forms of innovative care can be commissioned and implemented, not in an atmosphere of fear, but in an atmosphere of supported endeavour.

4.4 Flexible care mapping to include technology innovation

Covid-19 has given us a platform to think differently and has shown how important technology has become. The Government needs to ensure that we build on that foundation. Covid-19 must be viewed as the steppingstone to a technology-first principle in social care. Many people who require care and support are avid users of technology in their daily lives. Yet when they require care and support, they are often faced with arcane paper-based systems created for other people to control their choices.

People are becoming used to regulating their own lives with technology, be it in how they communicate with their families, how they shop or how they plan for their care needs. They are becoming used to making web-based choices, and there is the opportunity for the mapping of care pathways (discussed in section 3.6) to be online. An online mapping tool could help people plan their care and pathway, offering them the options and the various ways to achieve the outcomes they want with the support they want.

4.4.1 CASE STUDY
YOURmeds

The US website *Aging Care* reports that "55 per cent of the elderly are non-compliant with their prescription drug orders, meaning they don't take their medication according to the doctor's instructions".[51] The World Health Organization (WHO) reports that "in developed countries, adherence among patients suffering from chronic diseases averages only 50 per cent".[52]

Among the main reasons cited are an inability to read the small print, memory and hearing loss and social isolation. YOURmeds realised these issues and set about creating a solution. The co-founders, Dr Nitin Parekh and David Appleby created a medication management system that could empower people to take control of their own medication with the support of their network, allowing them to stay independent in their own home for longer. They work to a manifesto of creating technology that is simple to use, easy to understand and is not restricted by a user's technological literacy. The result was *YOURmeds smart*.

It is the world's first intelligent medication support solution. It prompts, records and notifies in real time what has happened to each medication round. Crucially, it conveys to clinicians and monitoring centres whether the right medicine has been taken at the right time. People are helped to self-manage their own care in the knowledge that they have a supportive back-up team, checking in on them, which will be activated if they take the medicines incorrectly.

West Lothian Council is one of the UK's first local authorities to introduce YOURmeds. It calculates that this has saved them £9.10 for every £1 spent, allowing vital resources to be redeployed where they are most needed. Data used quickly identified patterns of behaviour and, consequently, additional packages of care were put in place where required, supported with robust data surrounding adherence and compliance. Data from the pilot showed 83 per cent compliance from the NHS baseline of 50 per cent, further improving the effectiveness of the medication and patient wellbeing.

Angela Spink, the Social Care Manager in West Lothian, concludes:
"The data speaks for itself, YOURmeds has become a powerful tool for West Lothian – it's reduced costs, allowing us to redeploy care where it's most needed, increased adherence and compliance, provided evidence-backed assessment to aid medical diagnosis and provide peace of mind for those shielding. We plan to continue to steadily build on this, widening our catchment and introducing more users over the coming months."[53]

YOURmeds can demonstrate success both quantitatively and qualitatively. They have successfully completed more than 40,000 medication rounds for three councils, with an adherence rate of 79.7 per cent, far above what has been recorded previously. The feedback from users and their families is particularly important and the solution is constantly being improved, so that the packs have been made easier to open and the volume on the tag has been made louder. There is now demand for YOURmeds in Holland, where the Dutch Government is trialling its use in mental health, and in Australia where a large pharmacy chain has agreed a three-year distribution deal.

YOURmeds is easily scalable. However, for it to take off in the UK, there needs to be agreement between the health and social care authorities that it meets a large demand. YOURmeds helps people to remain independent and by creating support networks delivers a substantial cash saving to all care stakeholders. YOURmeds is hopeful that the advent of ICSs will pave the way for YOURmeds to be adopted by both health and care services as a value-adding, cost-effective solution across health and social care.

The service set up by CareMatch (showcased below) is an example of how web-based planning could work. People requiring support are given the opportunity to match themselves with a carer who they think will fit their needs. A real personal relationship is formed supported by the technology, and the web-based tool (the available apps) forms the basis for a community of care focused on the individual. If this web-based care matching system could be replicated for a care journey, it would open the possibility of people taking even greater responsibility for the care and support they put in place.

4.4.2 CASE STUDY

Abicare CareMatch

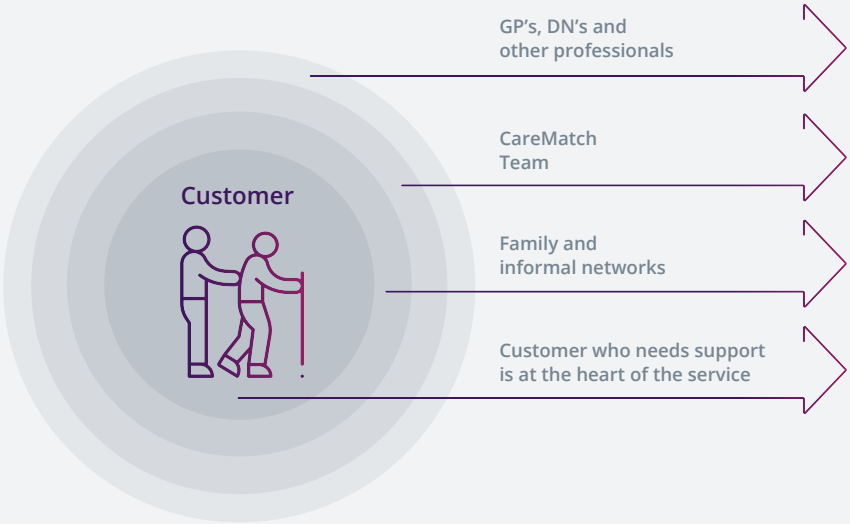
In homecare, the relationship between the carer and the person receiving care needs to be reimagined. At the same time, the care worker needs to have some control over their working patterns. Abicare's CareMatch does those two things seamlessly and provides many other benefits.[54] It is a model for how domiciliary care could work.

There are two sides to any domiciliary care arrangement: firstly, the person who requires care and secondly the person who is engaged to give that care. The most valuable skill in managing a home care service has always been the ability to match the two.

Abicare identified the opportunity to create a structure to support this relationship using technology. It built a web-based platform on which people looking for care can identify the carer who matches their needs, much like a dating app. The result is CareMatch, which operates as part of the Abicare Services Group.

The carer and the client can arrange the visits when they want, creating the flexibility to suit each other's schedule. The platform does more than match the needs of the person who requires care, it guides the client through the process of developing their own care plan. However, the most valuable aspect of the platform is its use of the 'onion model'. It takes a community to properly care for a vulnerable person. The onion model builds the community into a person's care plan by allowing informal networks, family, the CareMatch team and health and care professionals to interact with one another via the online platform. The CareMatch Client app and CareMatch Carer app are readily available on the Apple App Store and Google Play Store.

CareMatch works on an onion model



The CareMatch model provides value for carer members by helping them build a relationship with the person and their support networks. The platform cuts down the need for bureaucracy, so the carer's pay can be maximised due to lower overhead and fixed costs. The carer also knows that they have support from the other people in the care community reflected in the onion.

CareMatch's sphere of operations is growing steadily and carefully: each new scheme starts out as a pilot and, if successful, graduates into a fully fledged community. In a successful pilot, the clients transition from being local authority-funded to having their own Individual service fund, personal budget or individual budget, allowing them the autonomy to manage their own funding – with assistance in the case of individual service funds (ISFs). The potential to enhance the relationship between the carer and the care recipient is one of the distinguishing features of CareMatch. For example, the Essex CareMatch scheme allowed previously difficult-to-engage clients to take more control of their care. These individuals had greater control over the care package they were receiving and could request a flexible package that delivered their particular outcomes. That personal control is at the heart of the CareMatch solution.

The model is scalable and achieves the aim of increased self-management for clients in terms of their care and their money. The fact that it includes community and works for carers and the cared-for person makes it stand out as an innovative model, which smooths out many of the traditional problems of care at home.

During the roundtable, many people related the stories of how they got lost in an opaque system when trying to choose care options and how they felt lost and disempowered in choosing the right sort of care. Many local authorities now have care navigators, a system championed by HEE.[55] This is an impressive, innovative system, which should be championed locally and brought online, so people can navigate their own care with the fully mapped out choices discussed above.

PPP is calling for a system of online localised care portals, which clearly shows the care journey possibilities and helps guide people through the choices they have.

4.5 Focus on the person and the microlevel in communities

Innovation has to stem from the needs of people and communities. Innovative solutions should be judged on whether they enable people to manage their care more effectively for themselves, and on whether they increase a person's independence or autonomy and control. If innovation achieves these, then it will deliver the savings that will allow investment in new innovative goals and ways of working.

To achieve a momentum for innovation there is a need to involve people with lived experience, and there have been many attempts at this such as the VCSE Review initiated by DHSC, Public Health England, and NHS England.[56] At its heart is the co-design of health, care and public health systems with local people. In particular, with those who make most use of health and care services and with those groups and communities that are most excluded from those services.

The asset-based area *2.0 Social Care Innovation Network* – Phase II reinforced the need for system and behaviour change and the involvement of people with lived experience of care services.[57] TLAP, which has its own co-production group and network, and the VCSE Health and Wellbeing Alliance are examples of agencies set up to include people in decision-making.[58] However, their influence is sporadic and has not, in many cases, infiltrated mainstream commissioning. This is as a result of having been sidelined by the focus on dealing with acute and severe needs of people when social care intervention is needed at a time of personal crisis.

If regional areas or footprints are to commission for innovation, they need to recognise that involvement of community groups in a structured format is essential, a wholescale involvement of carers and people with lived experience is necessary. There must be guidelines and checks on decision-making about new innovations that means that they are either co-designed or at least vetted by the people that they are aimed to help.

One example of this given in the roundtable was by Dominique Kent. She said that the design of their services "started with two people in mind … the person receiving the care and the person delivering that care … and we worked with those people. So, our system was designed with our carers alongside our care recipients".[59]

There is an important discussion on the role for micro innovation in social care. Much as the Grameen bank pioneered micro credit as a way to give people power over their own lives, examples of community catalysts in England have given birth to great creativity and new ways of working. Alex Fox, Chief Executive of Shared Lives, cited the example of the community catalyst programme in Somerset, which held 425 community enterprises between 2014 and 2018, to help older people to stay at home.[60] These enterprises served 1,500 people in Somerset and created 372 jobs, fulfilling care needs and feeding local economic development.

This is micro-enterprise working at a local level. Although this should not necessarily be scaled-up, this enterprise could be funded by small scale, renewable grants and monitored by exception with a light touch. If people can be enabled to design and manage the support that suits them and their families,

they will lead innovation at a local level.

The Dutch Buurtzorg model is another way of building local networks to affect change in a neighbourhood.[61] Scaling down and giving responsibility to small, highly motivated and professional teams is a neighbourhood level approach that empowers people on a local level.

The Voluntary Organisations Disability Group (VODG) supports the engagement of the voluntary sector in this model of locally based innovation. It encourages engaging local partners to harness the potential of community resources to help people meet their aspirations and lead fulfilling lives. This way of working reduces social isolation and promotes inclusion by changing perceptions of disability and creating wider social and community benefits to support the needs of individuals.[62]

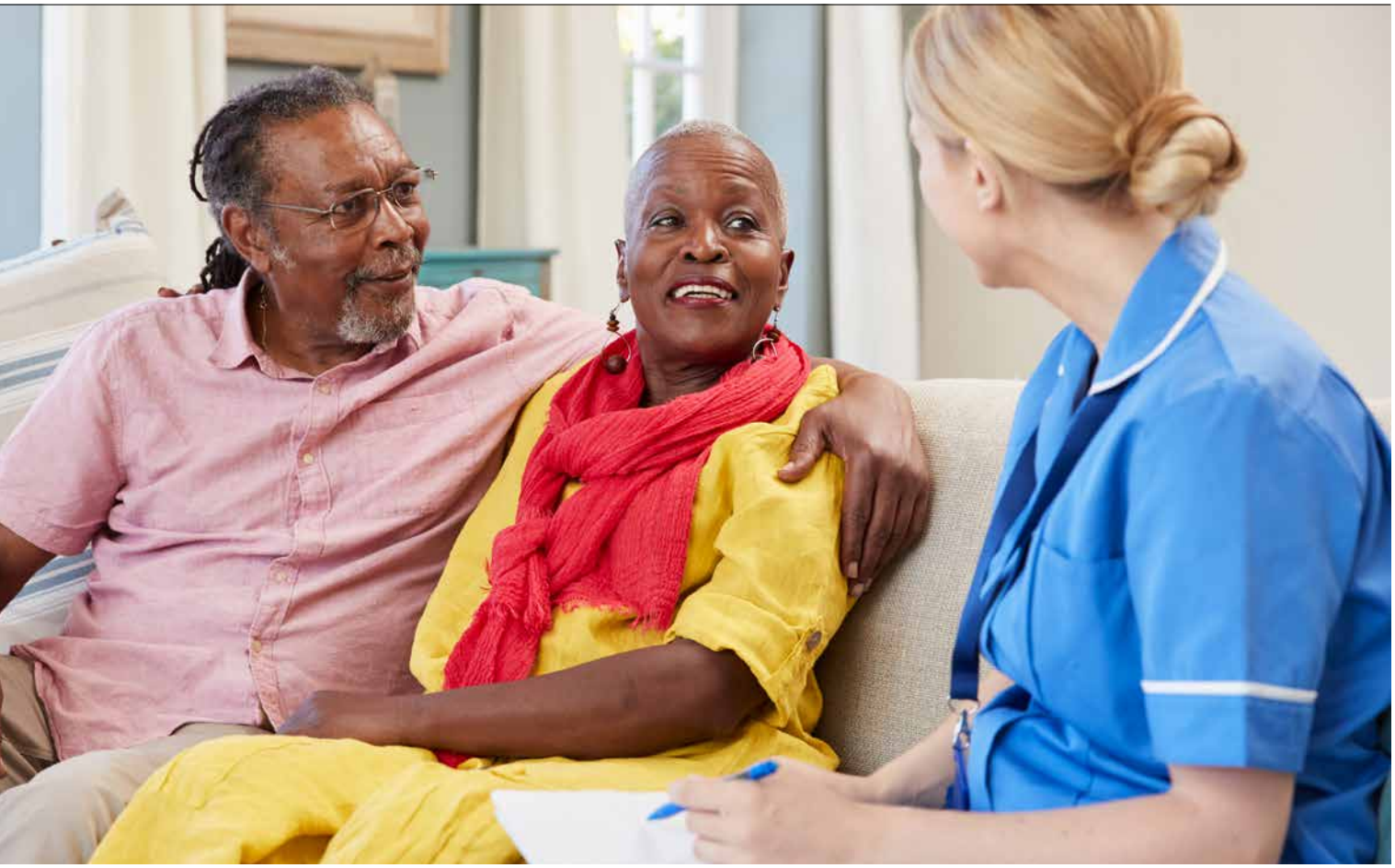
VODG's report, *Commissioning for a vibrant voluntary disability sector: the case for change*, draws upon the collective experiences across the VODG membership and explores some of the challenges associated with the commissioning of services for disabled people.[63] The report demonstrates more effective ways to engage social care providers beyond narrow commissioning cycles of care at a local level.

The model set out by TLAP in its *Innovations in community-centre support* a system for localised support, puts the individual at the centre of the care solution.[64] The model is designed to create structure to allow people to access care and support where they are. One outcome of this is that people will be enabled to 'age in place', a theme that will be developed in the infrastructure part of this report. For an example of this, see case study 4.5.2 on TLAP Matching householders with people in exchange for support.[65] This work is given structure by TLAP's *Making It Real Framework*, whose six themes (which PPP endorses) ensure that care is focused on the individual supported by organisations, supported communities and care workers.[66]

The Wigan Deal is a case in point of a local vision for innovation based on people's needs using an asset-based approach.[67] It requires an investment in staff training to facilitate groups to access training needs and design their own pathways. PPP recommends that initiatives such as the Wigan Deal should be accepted as a way for local authorities to stimulate innovation based on people's creativity and personal goals.

Funds must be released to finance smaller, community-led schemes. These do not necessarily need to be scalable models for larger innovation, but can be successful in the locality within which they have been implemented. PPP is proposing that regional innovation and creativity be stimulated by social care funds within ICS footprints to fund micro-enterprise and community catalysts. This would help to ensure that new models of care are based on community and individuals.

The experience of these initiatives being brought together in communities is an idea propagated by the Health Foundation to allow people to share their progress, findings and methods for implementing locally based innovative projects.[68] An organisation such as the Health Foundation could be funded to set up a community of innovative initiatives as a formal approach to the issue of recording and sharing innovation.



4.5.1 CASE STUDY

Gateshead Cares

Gateshead Cares is a ground-breaking system partnership between the commissioners and providers of health and care services in Gateshead, including the voluntary and community sector. It is now a formally instituted partnership between eight partners: Newcastle Gateshead CCG; Gateshead Council; Gateshead Health NHS Foundation Trust; Newcastle upon Tyne Hospitals NHS Foundation Trust; Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust; Gateshead Primary Care; Connected Voice (VCS); and Blue Stone consortium (CVS).

Its selling point is the collective leadership of the partnership which was invaluable in responding to the pandemic and has led to a new legal agreement, the *Gateshead Cares Alliance Agreement*. This puts a formal framework around working relationships built up over many years, based upon the representation of the people of Gateshead and a collective leadership and responsibility model. It is a way of working that exemplifies the aspirations of the Government white paper, in that a place-based approach within an ICS footprint has become the driving force of this collective leadership response.

The agreement is underpinned by a commitment to work collectively to ensure that Gateshead can make the most of future opportunities to meet the needs of local people. It provides a framework as the basis for further collaboration and has no fixed term, so it is positioned as an evolving agreement. The

partners signed up to the five pledges of Gateshead Thrives, which commits the partners to:

- Putting people and families at the heart of everything;
- tackling inequality so people have a fair chance;
- supporting communities to support themselves and each other;
- Investing in the local economy to provide sustainable opportunities for employment, innovation and growth; and
- working together to fight for a better future for Gateshead.[69]

Gateshead's collective leadership ethos has freed staff across the system to be flexible and responsive to local circumstances. During the pandemic, this allowed them to change the dynamic between health and social care by, for example:

- Redeploying community nurses to provide a bridging service between GPs and care homes;
- mobilising allied health professionals to backfill for community nurses when the community nursing workforce was 38 per cent down (for example, podiatrists provided footcare usually provided by district nurses); and
- deploying health staff to ease the path into care settings including extensive work on the discharge to assess (D2A) pathway.

The partnership meant that during the pandemic there has been a flexibility and agility in the local response, which has led to a truly place-based response. For example, hubs were set up to support communities e.g. free food delivery, routine shopping and delivering subscriptions. Redeployed staff made welfare and wellbeing calls to those shielding, and some GPs were relocated to offer walk-in clinics to encourage people to still seek clinical support. The voluntary and community sector provided an essential pathway to reaching the most vulnerable with essential services.

The partnership mobilised quickly to coordinate primary care and community services. They established a whole system approach to support residents in care homes e.g. community nurse practitioners visited care homes to give advice, support and train staff and community nursing teams continued to provide palliative care to support people at the end of their life. A care home multi-disciplinary team was led by community geriatricians, and a financial package was put in place, which allowed homes to claim additional expenditure above and beyond through a transparent open-book approach.

There are so many initiatives that have been born from this enhanced partnership arrangement, and Gateshead sees it as an important building block to further health and care integration. Key programmes of work are underway in 2021/22 around children and young people (SEND), older people (Frailty and Care Home Model), community mental health transformation and primary care network development. Side by side with these programmes, Gateshead Cares is focusing on the enablers of integration including digital and workforce agendas.

For Gateshead, this is the continuation of a journey where a collective place-base response is at the heart of care and health for communities.

4.5.2 CASE STUDY

Homeshare: Matching householders with people in exchange for support (featured in Think Local Act Personal's (TLAP) Directory of Innovations in Community-Centred Support)

What is the problem this innovation solves?

Homeshare brings together people with spare rooms with people who are happy to chat and lend a hand around the house in return for affordable, sociable accommodation. It is a simple concept with numerous and wide-ranging benefits for all participants. It has the potential to be an effective and sustainable response to several policy challenges, including tackling loneliness, helping an aging population stay in their own homes for longer, and providing affordable accommodation for young people, students and low-paid workers.

Solution

Homeshare brings together two unrelated people to share a home for mutual benefit. Typically, an older householder with a room to spare will be carefully matched with someone needing low-cost accommodation who can provide an agreed amount of support in exchange. Homeshare organisations carefully vet, match and oversee each unique Homeshare arrangement. The support provided might include: help with daily living tasks such as shopping, cooking and cleaning; companionship; overnight security; and/or engagement with social activities. Homeshare itself does not provide any element of personal care for the householder.

Evidence base

There is no formal academic research to underpin the difference Homeshare makes, but research headed by the Social Care Institute for Excellence was published in 2017. Case studies show the difference Homeshare is making to those participating and there is anecdotal evidence that supports that there are significant savings to be made due to a potential reduction in trips, slips and falls, and use of other services such as home help. There are also potential savings due to improved wellbeing as a result of companionship and quality accommodation.

Expected impact

Older people able to stay in their own homes for longer and live happier, healthier lives, and feel re-engaged and connected to their communities. Access to good-quality, affordable accommodation for a range of Homeshare participants. Bringing generations together and reducing loneliness and isolation in both young and old.

Stage/spread (where it is/how much is there?)

There are 21 Homeshare organisations supporting more than 500 Homeshare matches across the UK. Five of these organisations provide national coverage. The number of Homeshare arrangements is growing year by year. Several organisations started trading in 2019 with several more due to start delivering Homeshare during 2020, so we expect to see an impact from this over the coming years.

What would councils/areas need to do or have in place to enable it to happen?

Form working partnerships with existing Homeshare schemes or support/take a lead role in the development or expansion of schemes in areas not yet fully serviced by Homeshare.

What would kill it?

Lack of support and/or promotion from local authorities and local health and social care professionals. Lack of engagement by older people.

Where to go for more information

The national body for Homeshare is Shared Lives Plus. It provides support, training, events and resources for members and those interested in developing Homeshare, and aims to influence national and local policy.[70]
Website: www.homeshareuk.org Email: contact@homeshareuk.org

4.5.3 CASE STUDY

Nottinghamshire County Council

This case study of the Make the Title Nottinghamshire County Council Early Deterioration in Home Care Project in Nottingham and Nottinghamshire showcases innovation in technology working in a local setting to provide value for individuals and for the system as a whole.

Nottinghamshire County Council wanted to enable people to stay at home with a good quality of life for as long as possible. It saw that the best way to do this was to provide a homecare service that supported people to stay living independently at home while receiving support to maintain their health and wellbeing.

It saw the solution in the adoption of digital technology to allow health and local authorities to collaborate. The Early Deterioration in Home Care project group was born as a collaboration between Nottinghamshire County Council, Fosse Healthcare, Nottingham and Nottinghamshire CCG, Birdie Care (homecare software provider), East Midlands Academic Health Science Network (EMAHSN) and Nottinghamshire Alliance Training hub (NHS-led training body for health and social care in Nottingham and Nottinghamshire) and the local PCNs.

The project needed to understand the implications of developing a digital system solution, which could be adopted throughout the home care market. It had to be used to connect home care providers with GPs, emergency services, and the NHS to proactively identify and treat 'soft sign' changes of deterioration before they became larger critical care/medical concerns.

The success of the project is due to getting strong partnerships in place across health and social care. The PCNs were particularly important as the lynchpin, allowing the sharing of information and observations about a person in a digital format as part of the clinical care pathway.

The benefits of the collaboration have been that:

- People are receiving the care they need faster – for example, through earlier identification of infections followed by remote prescription of antibiotics;
- people and their families feel more assured that concerns are adequately followed up, particularly in a time where many have not been able to visit GP services for many months due to Covid-19;
- care workers can address issues in brief telephone consultations with GPs, whereas previously this would have resulted in several hours of work for GPs through unnecessary home visits;
- GPs and care workers are now developing new partnership-based working relationships. For example, where a GP asks the care worker to provide regular blood pressure observations for monitoring a patient over a period of time; and
- care workers can engage more closely in supporting care people with health concerns and experience a new professional development opportunity due to additional training and responsibilities – this attracts new talent and lowers attrition.

It has been developed across the one ICS footprint and could be replicated across others.

The development of the Birdie Home Care App has allowed early detection of any problems and a clinical or social care response at an early stage to avoid any deterioration. This creates value for the person and for the health and care services as a whole, because it allows them to work in a proactive, rather than reactive, mode.

While technology is at the centre of this project, its real beating heart is the collaboration across the statutory health and local authorities and the private sector. The approach of joint endeavour, in which the product was developed iteratively and developed, has borne fruit, and there is potential for greater benefit. The partners are now also exploring other projects such as direct integration of data from the Birdie App into the Nottinghamshire care record and expanding to other pathways, such as discharge home to assess.

4.6 Tech and data-led innovation

There needs to be a move among social care providers to revolutionise care using technology and data-driven improvement. The view of many people in social care is that there has to be a greater focus on innovation, creativity, digitalisation and use of data, to deal with the significantly increasing need for care and support.

The starting point in care is that every care provider should have a digital care records management system. This will mean that every person receiving care and support will have a digitised care plan, creating an ongoing narrative of their care needs. The use of care planning software is shown to release 10 to 20 per cent of care staff time and is starting to give data on a large scale.[71] The opportunities this creates to aggregate and analyse this data means policymakers can use individual records as the basis for data to inform care planning decisions at a local and national level.

Over the past year, NHSX has made a good start in this regard, with the inauguration of the dynamic purchasing system (DPS) for digital social care record (DSCR) solutions being the most recent success of the NHSX DCSR team.[72] This programme needs to be supported by adequate resource to ensure that digital care planning becomes the norm in social care and the building block for a data-led and person-centred system. The digitisation of people's records will drive the push for each person to have a budget based on their needs and the outcomes they want to achieve.

The adoption of digital care records is the start of the digital transformation of social care. The other building block of a digitalised care system are tools, such as remote medical monitoring and smart home technology (including online communication portals) to allow people to remain as independent as possible. These advances must be guided by the principle of interoperability, both within digital systems in the specific facility or service, and with other data systems in the health service. This will result in greater transparency and easier access to data for commissioners and regulators.

The possibility for closer constant monitoring of a person's condition will help avoid preventable hospital admissions and minimise the need for health interventions in care situations. Achieving this goal will require a significant drive to define standards for digital systems in care. Such efforts are already under way, coordinated by both the PRSB and InterOpen, with an overarching strategy being defined by NHSX supported by the social care sector representation organisations.[73] Among the latter is Digital Social Care, part of the Care Provider Alliance, which was set up and funded initially by NHS Digital and for which the funding is now provided by NHSX.[74] It is an important tool for supporting the social care sector to embrace the potential for digital transformation and should be set on a secure financial footing to promote digital uptake in social care.

4.6.1 CASE STUDY

Ally's resident acoustic monitoring system integrated with an electronic care management system

Ally transforms resident safety in care homes. Its wireless acoustic monitoring system helps residents receive safer care and sleep undisturbed by night-time interruptions.

In care homes, many residents often forget to, or cannot, use a nurse call system. To ensure they are still safe, much of the night duty staff teams' time is taken up visiting people's rooms to check on them. This can be several times a night and is an endless scenario. Not only does this mean incidents like falls are not detected or prevented, these regular checks disturb residents' sleep making them more likely to wake up, put them at risk of falls during the night and reduce their quality of life during the daytime. So, Ally Labs built the solution to the problem: The Ally resident acoustic monitoring system.

Ally's AI technology automatically detects when residents are calling for help, are awake and active, unusually restless or in discomfort. Staff simply check and review each alert via an app on their smartphone, deciding if residents need assistance. Using a system that safely and automatically detects when residents need assistance ensures staff no longer need to regularly check on residents, giving them a better sleep at night.

Not satisfied with simply building the monitoring system, Ally realised that it would be more beneficial for the staff and care home residents if the system were integrated with the care home's electronic care management system (ECMS). This would reduce admin duplication and further improve care outcomes.

At its most simple, the acoustic monitoring data allows carers to work safer and more efficiently. On top of this, Ally provides trend analysis on sleep changes to the ECMS to allow a clear picture to be built up of when action plans should be created to improve the quality of life of the resident. It also facilitates an investigation of potential underlying health issues that are affecting the resident's quality of life.

Before the integrated solution was set up, if staff were prompted that a resident was more restless than usual, they would then need to go to the ECMS to understand the possible reasons. Due to the integration, staff can receive prompt notification along with relevant information from the resident's care plan. This allows them to make faster, better-targeted decisions.

The implementation of Ally at three Friends of the Elderly care homes – comprising 90 registered beds – resulted in a 55 per cent reduction in night-time falls and a 20 per cent reduction in hospital admissions, compared to the previous nine months. This is at the same time as a 75 per cent reduction in the number of unnecessary physical night time checks conducted by staff, freeing their time up for other care planning and support activities (to the equivalent of about £13,000 efficiency saving per staff member per year).

Even where a care escalation or hospital admission was required, the outcome for a resident was likely to be better where the technology has picked up on a concern immediately. For example, in one of Friends of the Elderly's care homes in Malvern, a night staff team was alerted to a resident who was in distress. Acting immediately, the team called for an ambulance: it transpired that the resident had suffered a cardiac arrest. With prompt treatment in hospital, the resident made a full recovery and returned to the home two days later.

The manager of the care home in Malvern commented:

"We have learned so much about our residents through the system, which means our care is more appropriate and beneficial for them... Before Ally was installed, my team would often find residents had fallen in their room. This was distressing, especially since we wouldn't know how long they had been there. I now see the care notes saying, 'heard them calling for help' or 'found them on the edge of the bed'. My team can now assist residents before anything happens. I now hear stories on handover of how my staff have helped residents at night, rather than just hearing that everyone slept well. Whether this is a resident upset and crying because they were scared and confused, in pain, or even that they were cold because the duvet has slipped off. With Ally, my team can assist residents before anything happens. They are now much happier as they know they are providing safer, more appropriate care for our residents."

As well as the benefits to care outcomes and staff satisfaction, Friends of the Elderly has experienced improved conversion rates on new enquiries about its homes – boosted by awareness of this project.

During the Covid-19 pandemic, a remote installation and training package has been developed. This has meant that the resident acoustic monitoring solution can be easily installed across a care home group by untrained care staff, and the remote training capacity has ensured that Ally staff can deploy across more homes than was previously possible.

The only constraint to scalability is the availability of Wi-Fi within a care home, which is increasingly less of a problem, as most care homes are realising that they need an efficient commercial Wi-Fi system to operate efficiently.

NHSX's recent introduction of the digital technology assessment criteria (DTAC) for health and social care is a big step forwards to building the confidence of social care providers about the questions they need to ask regarding any technology procurement.[75] Together with the dynamic purchasing system, the DTAC starts to build a better procurement framework for social care organisations. However, this needs to be supported by a social care technology procurement framework taking into account the special needs of social care.[76]

The move to digital care planning must be discussed in the context of the Covid-19 pandemic. The experience of the pandemic demonstrated that the paucity of data coming from the social care sector was hampering efforts to map and control the spread of the Covid-19. In the concerted effort to garner social care data, the DHSC empowered Capacity Tracker to collect data from care providers based on each provider providing data to a standalone system.[77] This created an extra burden on care providers and led in many cases to providers having to populate data on multiple platforms for multiple audiences who insisted on having their own data source. Moreover, the lack of engagement and co-design with social care providers at the outset meant that they were initially reluctant in many cases to participate. Only when completion of the Capacity Tracker became the mandated gateway to accessing Infection Control Fund money did its adoption become universal.[78] Capacity tracker has learned from this and is now engaging with providers as partners, rather than as simply providers of data. The way forward is undoubtedly direct data collection from the digital care record systems of providers, followed by the analysis of this data at a local, regional and national level.[79]

The digital transformation of social care will require that all digital care systems have interoperability at their core. For example, if a homecare provider implements a care management system, it should link in with the tools to measure activities of daily living (see ADL Smartcare case study 4.6.3). Ideally these records should then feed into the shared care record systems being set up in each of the 42 ICSs across England. The aggregated data should then feed into overall analysis across a regional and then national footprint, allowing decisions to be made to facilitate the allocation of resources where and when they are needed most.

Innovation in digital care needs to be developed in conjunction with the new possibilities for technology-enabled care services, such as those that have been championed in the recent TSA/ADASS Commission recommendations to Government.[80] These technology-enabled ways of working can link together local initiatives and formal care structures, helping people to manage their own care needs and freeing up the time of care professionals to provide enhanced care. Technology-enabled care services for individuals have the potential to be the mainstay of a preventative model of care.

Digital workforce development is required to ensure that people working in care have a base level of digital literacy that allows them to use new technology to the benefit of the people they are supporting. HEE has released a health and care digital capabilities framework, which should form the basis of a campaign within the care sector to raise the digital capacity of its workforce.[81] This needs to be developed into a specific training resource for care workers, as part of the wider social care workforce strategy.

4.6.2 CASE STUDY

Anchor Hanover technology innovation

Anchor Hanover is a not-for-profit provider of housing and care for people in later life. It provides retirement housing to rent and to buy, retirement villages and residential care homes, including specialist dementia care. In total, Anchor Hanover serves more than 65,000 residents in 54,000 homes across almost 1,700 locations. Its residential care services employ the majority of the 9,000-strong workforce, providing services to residents at 114 care homes. Anchor Hanover operates in more than 85 per cent of local councils areas in England.

During the pandemic, the organisation has found that the innovative use of technology has enabled it to a) support residents to improve their quality of life and b) help residents to connect more easily with their families and friends.

1. Telemedicine

By using telemedicine, Anchor Hanover care homes have sent data to GPs, pharmacies and nurses to include blood pressure, heart rate, glucose levels and blood oxygen saturation levels. Training for care staff has been rolled out so that they can transmit the results responsibly and work more closely with health professionals. Care colleagues' training continues to be built upon to improve services to residents on a daily basis.

2. Memoride

By attaching a small chip to a pedal exerciser, Memoride enables users to pedal their way down Memory Lane or to new destinations that they have always wanted to visit. The motion generated on the pedals is fed to a tablet through Bluetooth, which is connected to Google Maps, and the journey is displayed on Street View. Memoride enhances the mental and physical health of older people, helping them to relive memories and make new ones along the way while enjoying a workout through their pedalling. Through using Memoride, residents in care homes have revealed more about themselves, their lives and experiences. In turn, this has enabled care staff to deliver more personalised services to these residents.

Service Improvement Advisor Diane Armstrong explains that Memoride is helping staff to tailor activities and aspects of care. Describing the experience of a resident who visited Benidorm through Memoride, she says: "He cycled past a restaurant (saying): 'I used to love eating the paella there!' So, we found out something new that he likes to eat, that we can serve him."

Plans are underway to use Memoride to enhance in rehabilitation and reablement to help improve mobility and reduce falls.

3. Communication

At the height of the Covid-19 pandemic, the impact of the lockdown and restrictions on visiting care homes risked increasing isolation and loneliness among residents. For those living with dementia, this risk was even greater, as many could not understand why their families and friends were unable to visit them. To address this, Anchor Hanover partnered with NHSX on a project using Facebook Portals to help care home residents to stay in touch with loved ones.

A further 10 Portals were secured for specific homes, so that residents could contact each other and remain in touch throughout the lockdown. These proved to be extremely popular as residents from numerous homes joined in quizzes, competitions, and singalongs.

Residents' happiness was monitored following meetings with family and friends, and there was visible improvement in mood, body language and expressions. Moreover, relatives reported that they were less worried knowing they had a means of contacting their loved ones.

Regular contact enabled residents to regain a sense of normality during lockdown, at a time when they had experienced a real risk of being isolated from their families, friends and communities. They have also enabled residents to attend special occasions and join in with major celebrations. Shirley Noble, a resident at Anchor Hanover's Springfield Care Home in Bradford, was able to enjoy her 90th birthday celebrations with all her family through using the Facebook Portal, and Arthur Drury, of Hatfield House, Doncaster, used one of the portals to meet his new-born grandchild.

4.6.3 CASE STUDY

ADL Smartcare – outcomes-based, data-evidenced care, which empowers the individual

ADL Smartcare's mission statement is: "Empowering people, through knowledge, to live better for longer." The organisation provides evidence-based data, research, knowledge and intelligence on age-related decline via their proprietary framework, which measures a person's ability to achieve the activities of daily living (ADLs). It then uses the data to inform independence-promoting interventions to help transform the lives of older adults. Using this approach, ADL Smartcare reduces the cost of care for the person, their families and the wider health and social care system.

ADL Smartcare uses the proprietary LifeCurve™ framework, which records data about a person and then provides advice to the person on how they can maximise their own independence.

LifeCurve™ is a tool based on research conducted by Newcastle University and ADL Research. The digital LifeCurve™ service, which has been developed from the framework, allows people to map age-related functional decline. It provides a simple framework for understanding the most appropriate stage to intervene and which interventions are most effective. It is based on years of research, and is easily understood by everyone, including staff in both health and social care sectors, as well as the clients themselves.

In addition, ADL Smartcare embeds professional advice by working with experts and professionals, thus helping people to maintain or even regain their abilities to live independently. In the case study highlighted, participants used the exercises that had been added to the LifeCurve™ framework from experts who specialise in exercise for older people.

In this case study, domiciliary care providers gave their carers access to the ADL Smartcare expert advice. By providing the expertise to the people who are already working with older people the reach is greater and no additional staff are required.

The study involved six clients, for each of whom the homecare service manager completed a LifeCurve™. The carers working with the clients, were then allocated an extra 15 minutes a week to encourage the clients to do the exercises that were relevant to them based on their LifeCurve™ position. Family members were also encouraged to get involved and support their relatives to do the exercises regularly.

After six weeks, LifeCurve™ were completed again. All participants in the study improved their independence and reduced their care requirements. The care provider involved was so pleased with the results that they continued to use the LifeCurve™ with clients after the trial had ended.

During the six weeks of the trial, the number of care hours required was reduced by 15 per cent overall. In addition, the provider involved continued to use the LifeCurve™ with its clients and was subsequently rated outstanding by the CQC in the areas where the LifeCurve™ was

being used. The LifeCurve™ gives the person control over who sees their data. Using the ORCHA-approved app and other ADL tools, a person can choose to share their data across agencies, allowing a joined-up, self-managed approach to their care.

The LifeCurve™ and associated services are a digital solution that requires no expert training, only familiarisation with the tool and the principles of the LifeCurve™. The solution is provided via an app and/or websites, which can be used on a variety of devices, such as tablets and mobile phones. In addition, APIs for this service are being developed so it can be integrated with other digital care solutions.[82]

To realise the benefits of this approach, contracts with care providers need to be based on outcome measures.

ADL Smartcare has conducted research that has estimated the costs of providing both health and social care at different points on the LifeCurve™. Using this information, as well as reducing care costs, providers can demonstrate the impact on health costs on keeping their clients more independent. Its evidence shows that for each person kept one stage higher on the LifeCurve™, their health costs are reduced by about £640 a year. These savings are not usually cashable but will equate to efficiency savings. See the graph below.

Health and social care costs across the ADL LifeCurve™

	Health Care	Domiciliary Care
Cutting toenails Going shopping Using steps Walking 400 yards Heavy housework	**£3,200 PA**	0-4 hours care **£2,800 PA**
Full wash Cook a hot meal Moving around Transfer from a chair Light housework	**£6,800 PA**	5-15 hours care **£8,000 PA**
Transfer from toilet Get dressed Transfer from bed Wash face and hands Eat independently	**£10,700 PA**	15+ hours care **£13,700 PA**

4.6.4 CASE STUDY

Nourish Care

Nourish is a digital care planning provider that supports digital care pathways across care services, including residential, nursing, dementia, learning disabilities, large groups and more. Its flexible digital platform can be tailored to each care service's characteristics and the needs of each person

receiving support. The app-based system is made of personalised timelines, interactions mimicking interactions of care, all linked to digital care plans, enabling co-ordination of different stakeholders in a person's circle of care including care workers in a care service, family and health providers. Its digital platform allows care teams to record at the point of care and analyse data over time to tailor care plans to the individual's needs.

Nourish launched in 2015 and has more than 1,600 care providers using its platforms, supporting more than 36,000 people. More than just a tech/software company, Nourish understands the value of social care and wants to empower teams to provide the safest and best-quality care possible to individuals. The company is positioned as a provider of digital transformation services for social care teams – most of its employees have significant care management expertise and Nourish is driven to empower care teams. The most important goal for Nourish is to allow care teams to care better, by enabling carers to spend less time on administrative tasks, and more time providing informed face-to-face, person-centred care.

Nourish was one of the first providers to be assured by NHSX as a DSCR supplier, and were also the first to be certified by the Professional Records Standards Body (PRSB).

Its growth and integration with third-party companies such as eMAR providers, pharmacies and others shows that Nourish is always evolving and adapting to the needs of the care sector. Other projects being rolled out include the e-Red Bag and GP Connect, features that aim to provide further interoperability with healthcare providers. The company is collaborating with other stakeholders to define a vision for what the care sector could look like in a world where all services are digitally enabled, and defining what this would mean for people drawing on social care, providers, commissioners, regulators and the NHS.

Given the importance of digital care planning in the context of integration, co-ordination of care across multiple providers, and improving safety and quality of care, it is essential that digital transformation continues to accelerate across the sector. Digital solutions for social care require a degree of person-centredness and user experience for care professionals, which is not available in incumbent healthcare solutions, while enabling interoperability with health IT systems. Nourish provides care providers with a platform that enables them to make the most of digital care planning, regardless of the size of their team, or the number of people they support, while focusing on each person receiving care, remaining compliant and collaborating with other health and social care providers around people they support across integrated systems.

Encompass (Dorset) use Nourish across a variety of care settings

Encompass (Dorset) is a registered charity and has been supporting individuals with learning disabilities and enduring mental health needs to live fulfilled and empowered lives for over 25 years. The Operations Manager at Encompass, Luke Stockley, says that Nourish is a logical system that is easy to navigate for staff at all levels of the organisation. It allows staff to develop care plans and monitor care with the person receiving care, their family and their circle of support, while freeing staff up from administrative form-filling, giving them more time to provide better care.

The Nourish system is flexible enough to be used in Encompass's supported living facilities, its registered care homes and in its community settings. It is so flexible that new protocols for visiting and testing were set up quickly during the Covid-19 pandemic and have allowed the settings to continue to be as safe as possible. It is this flexibility that marks Nourish Care out in the field of digital care records. The organisation says that during Covid-19, when management access to care facilities has been severely limited, they have been able to access vital information via the Nourish Care system to keep the care facilities running and provide high quality care.

Study in the Nursing & Residential Care journal

A recent study featuring Nourish has been published in the Nursing & Residential Care journal, evidencing how electronic care planning has benefitted the care sector in regards to job satisfaction and the delivery of person-centred care. The study, titled *Electronic Care Planning and Care Worker Engagement*, looked into care services using the Nourish platform, to find out what effects it had on carer engagement.

The study showed unequivocally that using Nourish Care systems allowed staff to do their job more effectively and efficiently. Using the system increased job satisfaction greatly, because it allowed staff time to spend with residents, focusing on delivering truly person-centred care.[83]

Country Court enhance person-centred care with Nourish

Country Court has more than 30 care homes specialising in nursing, residential, dementia and respite care.

Andy Colman, project manager for Country Court, says that Nourish has transformed how they care for older people by helping them give truly person-centred care, and having all interactions and risk assessments readily available allowed them to support the person in the most appropriate way. Each of Country Court's care homes operates slightly differently, and the team at Nourish have enabled slight differentiations in the systems at each home to cater for its unique way of operating. During Covid-19, using Nourish Care's care planning software has allowed managers to access information on the care home remotely and has helped them safely separate people into bubbles to keep them as safe as possible.

4.6.5 CASE STUDY

Dementia Support UK

Dementia Support UK (DS UK) is a simple, low-cost and high impact health technology service delivered by HammondCare, which supports people and organisations caring for people living with dementia. By subscribing to DS UK, an organisation can empower its staff teams to give a significantly enhanced care and support service for people living with dementia.

With funding from Innovate UK in a June to December 2020 pilot, DS UK delivered online resources for care home staff in England to download. DS UK also gave staff teams the opportunity for consultation time with dementia care

experts for more complex care scenarios via the purpose-built website (www.dementiasupport.org).

Following a review, further funding was granted by Innovate UK to refine the model for market. This included the development of an app to build a service around the needs of busy, mobile staff. The website and app give staff immediate easy access to a full library of resources, research highlights, an e-learning suite, live chat with a consultant and video consultation time with dementia care experts.

DS UK focuses on three key areas:
- describing planning;
- reablement; and
- pain management.

The pilot revealed the sheer complexity of care requirements that care home staff respond to daily. Using the Neuro Psychiatric Inventory Questionnaire (NPI- Q), DS UK can collate and analyse data to visualise the behaviours where care staff most frequently require support, how often these behaviours result in referrals for further health or care input, the reported severity of behaviours and the impact specific behaviours can have on care staff stress. This information can be presented at any level, for example at an individual care home or domiciliary care provider level, a regional level, a group or whole organisation level.

The service DS UK offers is currently unique in the UK and can be used in any care sector. It has been especially useful during Covid-19, at a time when face-to-face interactions have been limited.

It saves money too. Traditionally many organisations employ a dementia specialist with salary costs of between £31,000 to £45,000 per annum, DS UK which has modest subscription rates ranging from £2,500 to £10,000 per annum, depending on the number of permitted users complements such roles. It works to support existing organisational infrastructures and as such can be utilised in times of transition as new models of care are embedded.

A review of the pilot from June to December 2020 showed that there had been 5863 visitors to the website, and 63 video consultations were delivered to advise and inform complex care planning.

Respondent feedback gave the following results:
- 71 per cent reported a reduction in the behaviour issues of the person living with dementia;
- 65 per cent of people reported reduced staff carer stress linked to the behaviour issues;
- 65 per cent reported that they had avoided the use of a more expensive health resource;
- 82 per cent were confident in using the DS UK's advice and resources with other people in their care, so the advice given at one point had a wide-ranging effect on care delivery as a whole.

The beauty of DS UK is that it:
- enhances people's lives by ensuring they get the right care when they need it;

- gives an organisation a low-cost dementia specialist service;
- is accessible at all times;
- reduces carer stress, thus helping to avoid carer breakdown;
- can be incorporated as part of an organisation's dementia training plan;
- saves money for the organisation and for the health and care service as a whole by helping to avoid deterioration of the person living with dementia; and
- is easy to scale up and down.`
- This digital health innovation can be adopted at scale in a short space of time. It is a low-cost high impact service and is available now.

4.7 Conclusion

Innovation in social care must happen at a local level, supported by national structures. This structure needs to ensure an effective dialogue between health and care, where people with lived experience can work with care providers and community organisations to identify innovative solutions. At the heart of innovation is the need to improve the ability of those who require care and support to access care solutions based on their personal needs, not on generic models of care. There are many localised initiatives, small, place-based solutions and technological advances that should feed into transforming the system.

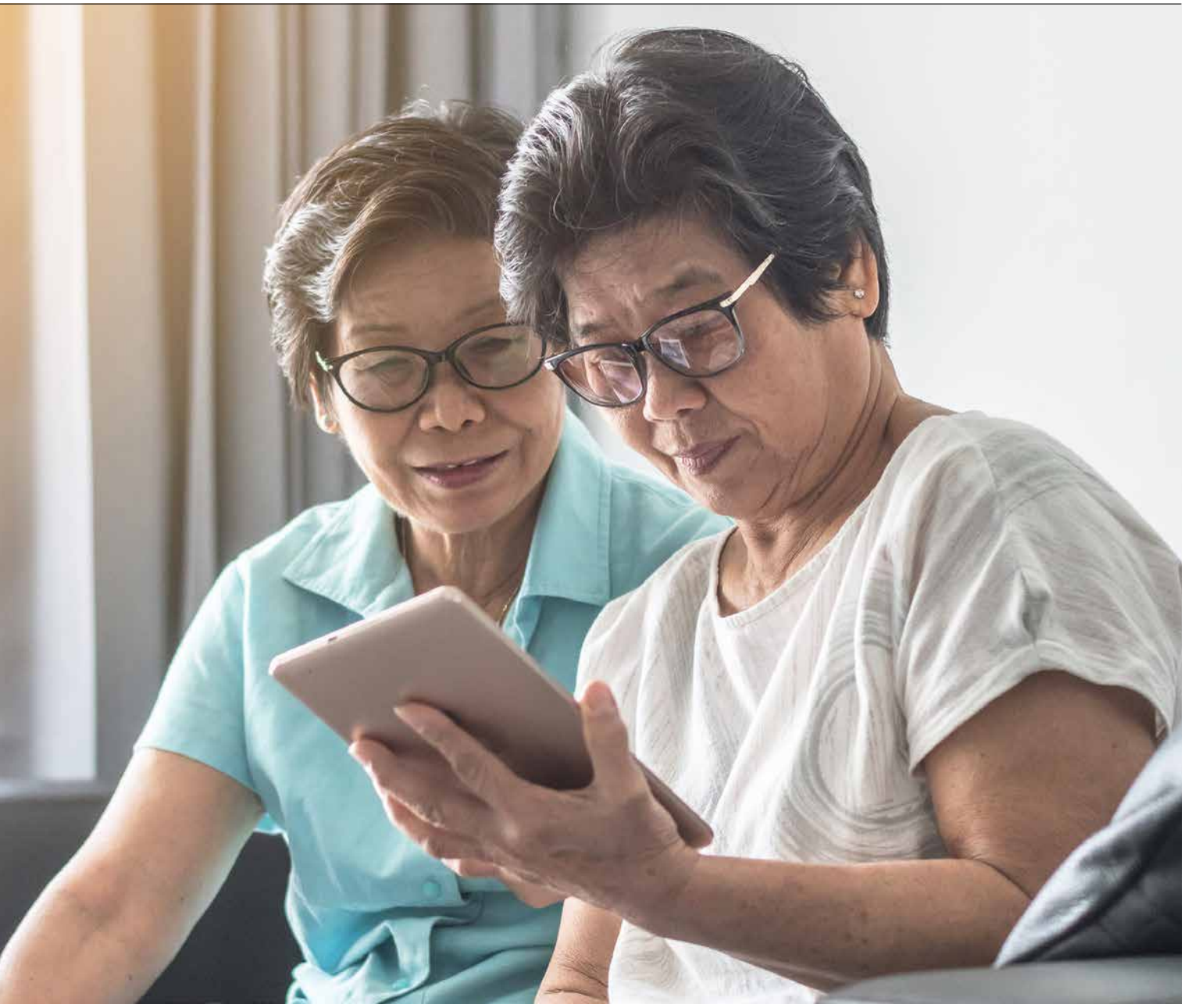
With care increasingly focusing on individual outcomes, it is necessary to base commissioning on outcomes rather than input measures. The advent of new technology allows us to measure outcomes in more detail than previously, and these measured outcomes should form the basis for a revamped commissioning structure that encourages responsible innovation.

Adopting a technology-first principle in care will allow people to see and understand the choices available to them regarding the care and support they want. With technology playing such a large part in people's lives, it should play a commensurate part in their care journey, and they should be able to evaluate choices against a nationally instituted, but locally accessible, care mapping service.

Much of the creative ability for innovation stems from people's lived experience and so individuals and communities must be encouraged by funding and local initiatives to take control of their own choices for care. There are several local and voluntary organisations detailed above that have put forward models for locally empowered innovation – such examples should be adopted or replicated on a wider scale.

While this report focuses on the need for local and personalised initiatives, it also stresses the need for technology and data-led innovation, as new care technologies open up new opportunities. Digital care records are at the centre of these opportunities as they have the ability to improve the quality of person-centred care and feed into aggregated data collection systems to inform local and national responses. These technological advances also include technology-enabled care services, which offer greater independence and the possibility to empower people to age in place accessing support either directly or remotely.

If technology is to be embraced in the care sector, then training in digital ways of working should form part of the workforce development plan recommended in the section on integration.



4.8 Recommendations

The vision PPP is calling for social care in England needs to encompass an innovation incentive to achieve better care around the person.

PPP recommends that a social care innovation evaluation model should be based on the value it creates directly and indirectly:

- For the person (the person requiring support and the person or people supporting them);
- for the organisation delivering that care; and/or
- for the health and wellbeing system as a whole.

PPP recommends the following:

1. The CQC needs to create an atmosphere where new forms of innovative care can be commissioned and implemented, not in an atmosphere of fear, but in an atmosphere of supported endeavour.

2. A system of online localised care portals, which clearly shows the care journey possibilities and helps guide people through the choices they have.

3. Each ICS should include a social care innovation unit to incentivise and evaluate social care innovations in its footprint.

4. NHSX should be given adequate budget to incentivise the take-up of digital recording systems for all care organisations, to ensure that small, medium and large care providers have the resources and expertise to implement digital care records.

5. A social care technology procurement framework taking into account the special needs of social care should be a focus of NHSX's work.

6. Social care providers should be involved even more closely in the development of standards for tech development with NHSX, the PRSB and InterOpen.

7. Digital care records should become the base for a single data platform for care providers to record care information, which can be collated for reporting and analysis by local, regional and national authorities as well as regulators. The aim is to ensure that care providers only have to complete one data platform rather than the many platforms they are currently asked to complete.

8. Adequate funding must be given to train the social care workforce via Skills for Care working closely with Digital Social Care.

9. The Government should ensure all new homes are care-ready and designed for digital accessibility to accommodate the changing needs of occupiers over their lifetime.

10. Technology systems collecting data in social care should be mandated to be fully interoperable with NHS data systems.

5: The funding of social care

- This section details the attempts that have been made over the past 12 years to find a new social care funding formula for older people's long-term care. Despite Government commissions and statements, nothing has changed. Local authorities and care providers have managed to survive but the financial pressures on them have grown.
- The inequitable treatment of people with social care needs as opposed to healthcare needs is continuing.
- The decision on a new funding model has to be agreed by the major political parties and take into account the views of all those affected.
- The solutions and issues discussed here relate to the funding of social care for people aged over 65. The funding of care for working-age adults raises very different issues and so should be dealt with separately.
- Value for money can be significantly improved by better use of scant resources to system increase access to information, by sharing funding across health and social care more effectively and by increasing access to respite care.
- Funding for older people's care can come from tax revenue, from people's personal assets/contributions or from insurance.
- The funding mechanism should be simple to implement and should take into account the needs of commissioners, the people who require care and support, and the providers of care. The principal funding base should be from state funds with the options for people to pay for enhanced care from their own means clearly set out.
- The funding system proposed in this report builds on much of the analysis included in the Dilnot Commission. However, the Dilnot proposals were too complex, would have created significant inequities that would not have been acceptable to many people and would have resulted in reduced income for care providers.
- The system proposed here is that people have to pay for care up to a percentage of their assets before becoming eligible for local authority funding. It is explained in full below.

5.1 Introduction

Reforming social care funding for older people's long-term care has been an unresolved issue for successive governments. Sustainable changes to funding have been proposed, but the implementation of reforms has not followed, because budgetary concerns have prevailed over political will for change.[84] The complex nature of the social care system has resulted in a lack of public understanding, and, thus, an absence of political pressure for change.

Research shows that when people are given more detailed information about how social care works, the overwhelming response is that reform is urgently needed.[85] Moreover, political support to improve the sector has only been extended to the point at which the public are asked to pay more.[86] Under the current system, if care home residents have total assets of less than £23,250 (including the value of their home) then they are eligible for local authority funding support. Even then, they are expected to contribute from their income and their pension towards the cost.[87] The means-test limit has been frozen at £23,250 since 2010 with the result

that access to state-funded social care is limited to those with the most acute need and a low level of assets.[88] Those who are not eligible for publicly funded services are exposed to the very high costs of care. About one in ten people aged over 65 will face care costs of £100,000 or more.[89]

The care sector has been consistently deemed close to the brink of collapse, mainly due to a decline in the real value of fees paid for care by local authorities since 2010 and the pressures placed on the system by the increases in the national minimum wage. The King's Fund noted in 2020 that a survey by ADASS showed that "nearly a quarter of directors of adult social services had no confidence that budgets would be enough to cover their statutory duties in 2020/21".[90] Covid is placing further financial pressure on the system and, as an example of the issues social care is facing, occupancy rates in care homes have fallen to 81 per cent compared to 92 per cent before the pandemic.[91]

The following summarises the various attempts to implement a fair funding system over the past 12 years.

5.1.2 Timeline of proposed funding solutions

2009: Labour Government published a green paper: Shaping the future of care together

This paper proposed that a National Care Service (NCS) be established. The NCS model was intended to protect everyone against the costs of care so that no individual would have to lose their home or their savings in order to meet these costs. The system would be based on the principle of shared social insurance.[92]

The paper considered three options to fund the NCS:

- A partnership model: People would be supported by the Government for about a quarter to a third of the cost of their care and support, more if they have a low income.
- An insurance model: Government would provide a quarter to a third of the cost of people's care and support, and make it easier for people to take out and insurance model to cover the remaining costs.
- A comprehensive model: Everyone would get free care when they needed it in return for paying a contribution into a state insurance scheme.[93]

The Government concluded in favour of the comprehensive model, which included a 10 per cent levy on top of inheritance tax to create a 'free' social care service alongside the NHS.[94]

This white paper was published in the run-up to the 2010 General Election, which the Labour Party lost. The new Coalition Government between Conservative and Liberal Democrat parties decided not to follow the proposed approach and so these reforms were never implemented.[95]

2010: The Commission on Funding of Care and Support

An independent commission, chaired by economist Sir Andrew Dilnot, was set up in July 2010 by David Cameron's Coalition Government to make recommendations for changes to the funding of care and support in England.[96] The commission considered a partnership model between individuals and the state, outlining how people could choose to protect their assets against the cost of care.

Key proposals:

- More generous means-testing threshold: Increase current threshold from £23,250 to £100,000 so that more people would be eligible for state support towards care. Those who had assets between £14,250 and £100,000 would pay a contribution towards their care, but costs would be met in part by the state. People who had more than £100,000 would pay for their care in full up to a maximum limit or until they reached the means-test threshold.
- Cap on care costs: The cap would be set at £35,000. Once an individual had reached this limit in personal contributions to the cost of their care, the state would pick up all ongoing care costs. Those living in a care home would have their ongoing living costs capped at £7,000-£10,000 per annum.
- Disability benefits support independence: Attendance Allowance and Disability Living Allowance would remain a feature of the support provided by Government.
- Reduce postcode lottery for care services: A national threshold for care eligibility. One level of eligibility across all councils, which would remove the local variability.[97]
- Lifetime cap of zero for anyone who had been in residential care for at least two years before the cap was introduced.[98]
- Standardised scheme of deferred payments: this would allow care charges to be made against a person's home, which would be recoverable on their death.[99]

The Care Act 2014 legislated for the introduction of a cap, but its introduction with a more generous means-test was deferred in July 2015 by the incoming Conservative Government led by David Cameron and has been indefinitely postponed.[100] The Cameron Government stated that, given the "time of consolidation", it was "not the right moment to be implementing expensive new commitments such as this".[101]

Rt Hon Jeremy Corbyn MP, National Care Service (2017)

The Labour Party manifesto pledged £8 billion of funding for social care over the lifetime of the next Parliament, with £1 billion arriving within the first year to serve as the basis for a National Care Service.[102] The £3 billion-a-year service would include shared requirements for single commissioning, partnership arrangements, pooled budgets and a joint-working arrangement with the NHS.[103] This National Care Service would form part of our universal public services, funded through general taxation, removing the burden of cost from individuals.[104]

Rt Hon Theresa May MP Government (March 2017)

Conservative Manifesto 2017

The 2017 Budget Statement announced that the Government would publish a green paper for consultation on options for how people paid for social care. This was never delivered.[105]

The green paper was supposed to contain proposals on social care funding reform, which would include:

- An absolute limit on what people need to pay
- A single £100,000 limit in the means-test.
- The value of the home to be included in the means-test for those in receipt of domiciliary care.[106]

Rt Hon Boris Johnson MP Government (July 2019)

The 2019 Conservative Party Manifesto did not mention a social care green paper, and its proposals provided little detail on how social care funding would be reformed.[107]

On 24 July 2019, Prime Minister Boris Johnson declared: "My job is to protect you and your parents, or grandparents from the fear of having to sell your home to pay for the costs of care."[108] Due to the pandemic, there has been no further action on this area of policy.

The above timeline of proposed funding models shows that the last concerted effort to reform the funding system was the independent commission, chaired by economist Sir Andrew Dilnot. It was set up in 2010 by David Cameron's Coalition Government to make recommendations for changes to the funding of care and support for older people in England. The Care Act 2014 legislated for the introduction of the Dilnot-recommended cap, but its introduction was deferred in July 2015 by the incoming Conservative Government, with commencement postponed indefinitely.[109] While Prime Minister Rt Hon Boris Johnson MP has said he has a plan and indicated that he would like a solution that means that "no one should have to sell their home to pay for care", no plan has been published nor appears to be forthcoming soon.

5.2 The issues for consideration in defining a new social care funding system

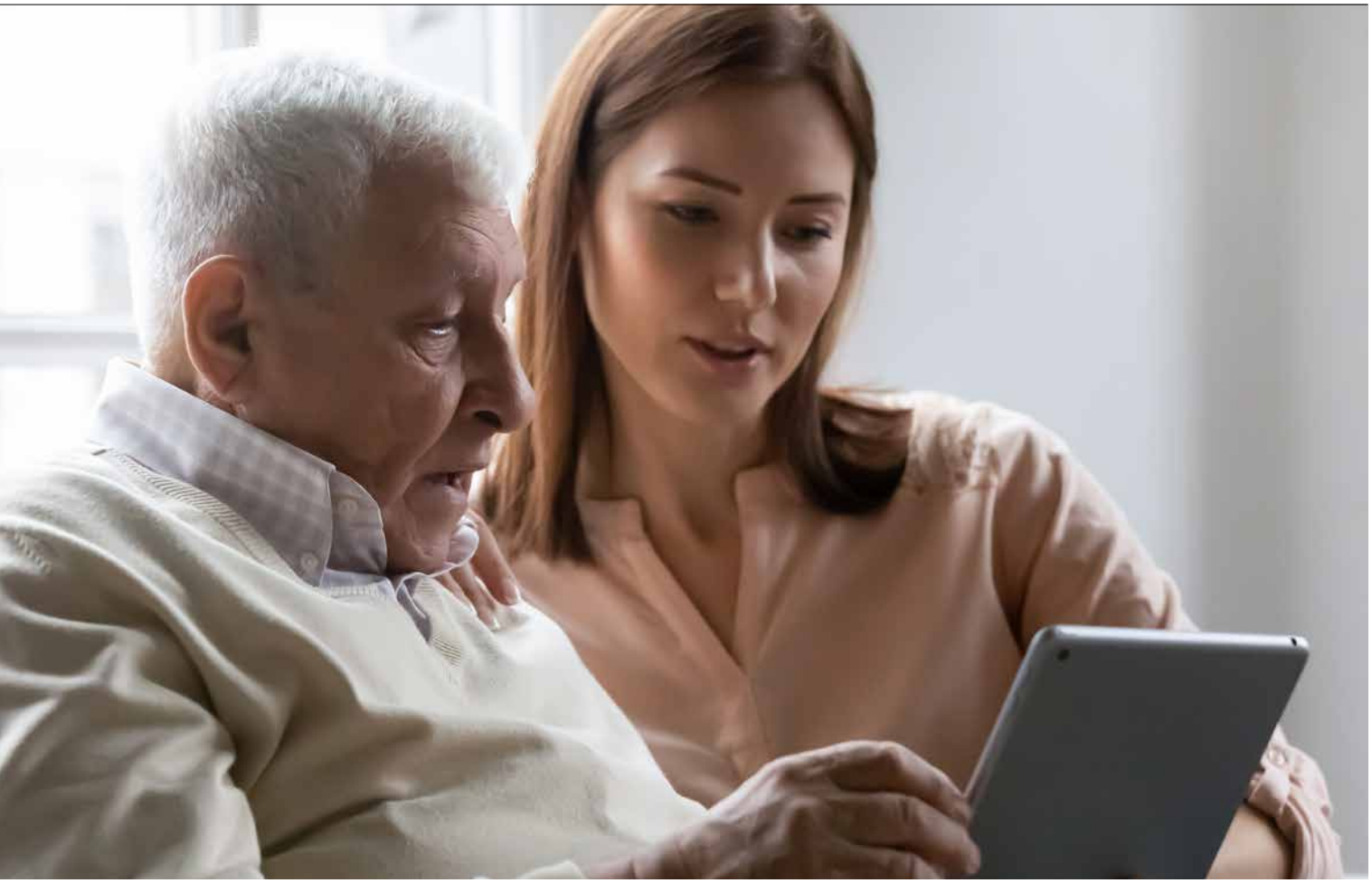
5.2.1 Discrimination: social care the poor cousin

At the heart of the issue of funding in social care is inequity. People who need to pay for their care feel they are being disadvantaged simply because their condition is not deemed to be a healthcare condition. At the PPP roundtable in June 2021, Jeremy Hughes, formerly CEO of the Alzheimer's Society, recalled that 10 years ago (coinciding almost exactly with the Dilnot Commission) he had spoken at the first Dementia Action Alliance meeting, at which the then Secretary of State for Health was presented with a question that he simply couldn't answer: "My Mum has dementia and gets no support from the state. My Dad has cancer and gets all his support from the state. Why is that?". That fundamental inequity still remains. Research by the Alzheimer's Society for the period from 2017-2019 showed that care for people living with dementia is paid mainly by individuals out of their own pocket: it found that in that period £14.47 billion had been spent on care by people with dementia compared to £9.3 billion by the state.[110]

Two years after the Dilnot Commission, the then shadow Secretary of State, Andy Burnham, commissioned an independent report on whole-person care, chaired by Sir John Oldham. The latter proposed "that health and social care should do more to support people with long-term conditions to become engaged in managing their health and healthcare … [highlighting] that health has physical, psychological, and social domains, and that an integrated understanding of health should inform how public services work with people with long-term conditions and how services are organised and paid for locally and nationally".[111] Little has changed in the intervening years.

5.2.2 Political agreement

Any solution must be acceptable to the main political parties and, by extension, to the general public. It has to offer stability and satisfy the needs of the people who



require care and support, the needs of the commissioners and statutory payers of social care and the needs of the providers of care (mainly private, not-for-profit or community-based providers). Any solution will cost more than is currently being spent by the Government. There has to be a strong political will to change the system if new proposals are to be followed through to implementation.

A view expressed at the roundtable was that a funding system based on tax revenue ensures there is shared financial responsibility, but in the present system it means the transfer of resources from the taxpayer, including younger people, to older people who hold the majority of the housing wealth. If a solution is to be acceptable to all (or at least a majority) of the electorate, there needs to be a balance between giving sufficient money from taxpayers to property owners and trying to limit the feeling of unfairness that property owners feel in that they are punished for being prudent and self-sustaining.

5.2.3 Working-age adult care and care and support for older people

This report discusses solely the issue of care for older people in England. It should be noted that some roundtable participants expressed the opinion that a complete solution for care funding could not be discussed without taking account of the needs of working-age adults requiring care and support. This section of society has different care and funding needs because:

- On a per capita basis, they attract the largest cost in terms of social care. Their numbers are growing, and they will need life-long care in most cases;
- In most cases they cannot be asked to self-fund, because they will not have had a chance to build up their own income or assets; and
- Local authorities have to provide their care and support, because of the long-term nature of their needs.

While it was acknowledged that ideally a solution would be proposed for working-age adults, it was decided that that would have to be the subject of future discussion. The mechanism for funding care for working-age adults will always have to be based largely on tax income, and the limits on the amount and length of support needed require very different actuarial considerations. In most cases, care for working-age adults is developed specifically around the person, will be active in designing their own care package and managing the resources at their disposal.

This future discussion will potentially cover the specific funding issues relevant to borderline cases, namely where care for working-age adults meets care for older people. Clearly, in many cases, people with physical, mental health or learning disability support needs will go on to require care after the age of 65. Furthermore, specific consideration is also needed of the care funding transition for an under-18-year-old into the adult care system.

5.2.4 Lack of joined-up thinking

When the care and health systems are considered as one continuum, it is easy to highlight the waste in the system. All participants expressed the view that much of the funding allocated to the NHS could be used more effectively and more efficiently if some of it were employed within social care. The Alzheimer's Society report referred to above indicates that from 2017-2019 there were one million unnecessary hospital bed days costing £340 million directly as a result of the social support not being available for people who could not afford it.[112] The result was that these people remained in hospital longer than necessary. Not only is this a striking and shocking example of poor management of public funds, it also results in poorer outcomes for the individuals concerned.

The shocking and endemic waste of public resource is indicated by the following example discussed at the roundtable. This example is all the more striking for being a common occurrence. The wife of a person living with dementia in the last two years of his life had had eight different individuals from health and social care coming to support him and give him advice, guidance and practical help. She had to retell her husband's story every single time to each of those eight people. In each case the availability of help and support was limited by the funding and service mechanisms of that provider and in many cases was contingent on other service provision to be effective. There is an acute need for central leadership to co-ordinate across the different funding systems. Huge benefits in economic and personal terms would be gained from real ownership and leadership at all levels.

Four specific areas were identified where the care and health system as a whole would benefit, were funds to be diverted from NHS funding:

- Information services: as referred to previously in the integration section of this report, people do not know what options to choose. Good information and an investment in guidance portals, which provide comprehensive and comparable information as to the options, would enable people to make more informed choices and live longer, potentially in their own homes.

- Community support: the NHS Long Term Plan does promise some transition funding from NHS budgets into social care budgets, and it was suggested, for example, that more resources should be made available to make social prescribing more widespread.[113]

- Domiciliary care: providing care at home is probably one of the most efficient ways of supporting people who need care. The poor funding of homecare by local

authorities hampers its potential as one of the main ways to support people to live longer and healthier in their own homes without recourse to more expensive care. US President Joe Biden has realised the power of homecare and put immense budgetary resources behind it.[114] A similar move in the UK could yield great benefits.

- Respite care: people being cared for at home by a family carer could live longer at home and with a better quality of life, if there was better access to respite care to relieve the carer regularly for short periods. This has been one of the main planks of the Japanese care system since 2000.[115] In the UK, there is very little incentive, or indeed opportunity, for much of the care sector to provide the flexibility for respite care. When respite is needed, it has to be paid largely by individuals rather than funded by the state. The savings to the system by having an effective respite mechanism are undoubted. The 2014 report on carer breakdown by Carers UK found that:

    - 46 per cent of carers had fallen ill but just had to carry on caring;
    - One in nine carers said the person they cared for had to be rushed into hospital, emergency care or that social services had to step in to look after them while the carer recovered from illness; and
    - One in five carers were forced to give up their jobs because they were in crisis.[116]

The effectiveness of investment in respite care cannot be understated, and it could mitigate the economic loss, which is highlighted in research by the Alzheimer's Society in 2019.[117] The research quantified that businesses lost £3.2 billion in one year due to carers having to quit their job or change their working patterns to care for someone living with dementia. It is estimated that this figure will rise to £6.3 billion by 2040.

5.3 Sources of funding for care

So how can care be paid for? The roundtable heard from many contributors that it is important to look at all the possible sources of funding for care, whether they be from the state (the NHS, pension or welfare/housing benefits) or by individuals in some way, either directly or via increased taxes or insurance schemes. These sources are discussed below in some detail.

5.3.1 Tax and the public purse

The roundtable heard views in support of funding via taxation: "The fairest system for funding anything that's essential in society is general taxation. That's how we fund the NHS, education, fire and police service because it's a collective will." It was claimed that the House of Lords Economic Committee agreed that funding care from taxation was the only solution that worked, because anything else depends on choice: choice to pay privately, or choice to pay into insurance, or choice as to how a person uses their own assets.[118]

If taxes are to be the bedrock of funding for older people's social care, there needs to be a review of the different pots that a person can access to pay for care. Person-centred care means looking at all these different pots and considering how the total amount of money could be used to support people to live where they want to, in the style they want to and with the support they need. The following 'pots' were identified:

1. Local authority funding: from the central Government allocation to local

government and, in the recent past, from locally raised taxes (i.e. council tax adult social care precept).[119]

2. NHS Continuing Healthcare: a payment from the NHS in England for people who require a high level of nursing care. This is often a hotly contended issue, with many people who claim they are eligible being refused, leading to many disputes and costly deliberations. For many people, NHS Continuing Healthcare is a minefield, and its administration varies across the country. The National Audit Office reported in 2017 on the failings in the system, and there has been no systematic change to regulation since then.

3. NHS-funded nursing care: the NHS pays for the nursing care component of care home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.

4. Carer's allowances: This needs to be taken into account alongside the financial support for the individual with the long-term condition. A person receiving carers allowance could potentially also apply for support from a local council, a council tax reduction, universal credit, pension credit, income support, income-based employment and support allowance and a range of welfare benefits.[120]

At present, these funds are overseen by different government departments, in different places, with complex and differing eligibility requirements. The acute ever-present need is for a real joining-up with one much simpler, easily accessible system for eligibility and care support assessments. Roundtable participants were in consensus that these need to be brought together.

One way of potentially achieving this, at least in relation to some older people in need of care, is to explore the increase in the use of personal budgets.[121] These have had some success since their introduction for working-age adults with long-term support needs, following the policy paper *High quality care for all: NHS next stage review final report* by Lord Darzi in 2008.[122] Although the remit of the current personal budget system is narrow and presents many difficulties for recipients, it could provide a better single-pot approach to streamlining and clarifying the benefits available to an individual from the public purse. With variation, the personal budget scheme could be extended to older people requiring care, although this would require research on how it could be administered for an older person.

The fundamental point, however, is that increased government taxation is needed and has public support. A survey conducted by Ipsos MORI on behalf of the Health Foundation found that 62 per cent of people in a survey of 2,000 people thought that if the Government decided to increase spending on social care, this should be funded through some form of tax increase, up from 51 per cent in May 2018.[123] Many people think that this percentage will be even higher as a result of the Covid-19 pandemic.

Consideration is also needed regarding the use of scientific knowledge and actuarial insights. One participant proposed increased use of genetic profiling, with a view to assessing whether and when people are likely to require care and support. It is mentioned here, although the scientific and ethical barriers to such individual profiling need further research and public debate before it could be a viable tool within the publicly funded social care system.[124]

5.3.1.1. CASE STUDY

The funding of care in Denmark

As presented by Sven Erik Bukholt, Senior Advisor, and Rasmus Lyager Brønholt, Head of Section at Department for Senior Citizens at the Danish Ministry for Social Affairs and Senior Citizens at PPP's webinar *Social care: a global challenge.*

Care in Denmark is fundamentally based on the following principles:

1. Universalism. The core principle is that there should be equal access to almost all services, irrespective of a person's labour market status, nationality or income. Furthermore, the system is primarily tax-based, not insurance or contribution based.

2. Decentralisation. Denmark is made up of five regions, which include 98 municipalities. Each region provides a universal free public health service similar to the NHS, and then the 98 municipalities provide a varied range of services, including social services for children, the elderly and people with disabilities, as well as schools, day-care facilities and job centres. The municipalities have a relatively large amount of freedom to plan activities, including determining their own service levels and how they wish to prioritise between different services. They ensure the availability of the necessary services and allocate national service funds to older people from the municipal budget. The system is legislated for under the National Act on Social Services, which sets out centrally what needs to be achieved, while the municipalities can decide on how they achieve their targets by use of private enterprise, their own services and/or working with non-profit organisations.

3. Care around the person: The need to consider the view of the person receiving care with the purpose of them preserving their independence as much as possible. This is seen in practice by the fact that all Danish municipalities are obliged by law to establish a senior citizens council, which promotes inclusion, dialogue and co-operation between older people and the municipality.[125]

The funding of care

The funds for social care come mainly from the municipal tax revenue and block grants from the national government. Those programmes include a general grant and an equalisation system that takes into account the different tax situation and demography of the individual municipalities. The overall economic framework of the provision of services is negotiated annually by local government and the Ministry of Finance.

Care is divided into four elements:

1. Preventative measures, including home visits and activities to supporting good health and wellbeing.

2. Rehabilitation, which includes measures such as medication reviews, nutritional interventions and measures for tackling mental health issues. ➤

3. Home care, which covers personal care, practical help and support services and food services.

4. Nursing homes.

The focus in Denmark is firmly on homecare.

Each municipality is required to:

1. Determine its own quality standards for long-term care. The municipalities are audited by a centralised system of supervision; and

2. Formulate a dignity policy that describes the overall values and priorities in the field of elderly care, which includes the following areas:
   a. Quality of life
   b. Self-determination
   c. Quality and co-ordination of elderly care
   d. Food and nutrition
   e. A dignified death
   f. Relatives
   g. Loneliness

Workforce

Denmark, like most other countries, has difficulty in attracting people to work in social care. In 2019 it set up a task force to consider this issue, and recommendations were put forward in 2020. It was decided that municipalities were obliged to employ adult students and to ensure they get a salary during the initial basic training and receive further financial support in the early stage of their career. The Government has allocated funds to finance new career pathways for care workers.[126]

5.3.2. Personal assets

There was a strong feeling amongst roundtable participants that although there should be a base level of social care for everyone, funded out of national taxation, people with the resources would always want the option to pay for a care in an enhanced environment. People should always have the option to use whatever assets they want (whether that be their investments, their pension funds or their property) to pay for an enhanced environment for care.

When discussing care for older people, it is hard to disregard the fact that prime among their assets is property. In Britain, it is calculated that people over 65 have £1.7 trillion in housing wealth.[127] Research conducted on behalf of the Equity Release Council (ERC) in 2019 presented evidence that the majority of homeowners aged 45 and older see money invested in their property as part of their later life plans, and 37 per cent of people aged 65 or over think that money invested in property could be used as part of their plans to pay for care if needed.[128]

The participants in the roundtable agreed that capital tied up in property could in some way fund care needs, but that the Government aspiration that no one should have to sell their house to pay for care would need to be recognised. The participants heard from Jim Boyd, CEO of the ERC, about the potential for equity

release to support individuals to age in place and live independently in their own homes for longer, by funding home adaptations and tech-based support. The most popular equity release product is a lifetime mortgage, where a person takes out a mortgage secured on their property, and the loan amount and any accrued interest is paid back when the person dies.[129]

The ERC research stated that 67 per cent of people over the age of 50 are determined to remain in their own home if they need care in the future. The surprising results of the research were that the main reason was not the cultural attachment to the home, but the sense of unfairness felt by homeowners who had been encouraged to behave responsibly throughout their working lives by saving and investing in housing.

A recently hatched initiative is being championed by a few charitable care providers who have seen opportunity of setting up a vehicle to allow people to borrow against their home when they move into a care home while renting it out, so that they can retain the property. Typically, the person would be able to repay the loan after 10-15 years, and they are calling for a marketplace for the vehicle known as care loan repayment partnerships (CLRPs). Shaw Healthcare, which is leading the group, is calling for these schemes to be validated by local and central government.

5.3.2.1. CASE STUDY

The funding of care in Ireland

As presented by Sandra Tuohy, Head of Operations for Older Persons Service, HSE Ireland at PPP's webinar Social care: a global challenge.

Ireland does not have a free-at-the-point-of-need healthcare service. However, it does have a health and social care system that is fully integrated.

Social care is delivered through a nursing home support scheme and a home support domiciliary care scheme.

The nursing home support scheme (the Fair Deal) supports about 23,000 elderly people in nursing homes and costs €1 billion per annum.[130] The homes are mainly run as private enterprises, and are predominantly small, family-run businesses. The €1 billion is funded through a dual tax and personal contribution system: a resident paying nursing home fees will have to contribute annually 80 per cent of their "assessable" income and 7.5 per cent of the value of any assets in excess of €36,000.[131] If the assets include land and property, the 7.5 per cent contribution based on those assets can be deferred until after death and may be collected from the person's estate. The person has to pay for a maximum of three years in a long-term care facility. The majority of people over 60 in Ireland are property owners, and so it is easy to base the system on property wealth. The €1 billion paid into the nursing home scheme by the Government is largely recouped by the payments from the assets from people moving out of the scheme.

In addition, there is a transitional care funding arrangement model, which pays for the first three to four weeks after coming out of hospital until a person's needs are fully assessed.

Reform of social care is focused on rehabilitation and on supporting more people at home. The home support domiciliary care scheme costs the Irish Government €600 million per annum and requires no payment from the person receiving care. In 2020 it delivered 18 million hours of home care, and in 2021 it is aiming to deliver 24 million hours to 55,000 people. People are keen to take advantage of the system, which reduces the overall number of people who have to be referred to hospital. This works because the health and care systems are integrated, and so the savings made on reducing hospital care can be used to finance the care system

Like most major economies, Ireland has difficulty attracting people to work in adult social care and so is implementing a workforce plan to enhance career training and progression, increase the renumeration for carers, and improve the terms and conditions under which they are employed.[132] This is especially important because care staff are increasingly being required to look after people with multiple co-morbidities and more complex issues. There is also an apprenticeship scheme for school leavers or for anyone interested in becoming a social care worker and a career progression plan that runs up to management level.

5.3.3 Insurance model

In the PPP symposium on care funding systems in countries other than the UK, referred to above, Dr Yasuhiro Suzuki, Advisor to the Ministry of Health, Labour and Welfare, Government of Japan, was keen to stress that "people should not be given a free lunch". By this he meant that people should be asked to contribute some of their own assets to pay for care, by way of a form of hypothecated taxation or by insurance premiums so that they make some discrete (i.e. not general taxation) financial contribution to paying for their care in the future.

There was some support at the roundtable for trying to enhance the market for long-term care insurance. Although there was no appetite for a compulsory insurance scheme such as that in Israel, there was some appetite for pressurising the Government to help create a market.[133] If the tax-based system could be simplified (see section 5.4), and the pots of money available for care amalgamated, this would provide greater stability and transparency, which could help create better conditions for an insurance market. If there was greater clarity on social care models and funding, insurance schemes could be part of a solution to give people peace of mind that they could afford the care they wanted.

5.3.3.1. CASE STUDY

The funding of care in Japan

As presented by Dr Yasuhiro Suzuki, Advisory to the Ministry of Health, Labour and Welfare, Government of Japan, at PPP's webinar Social care: a global challenge.

Prior to 2000 the Japanese care system was funded purely from taxes, and access to funding was means-tested. The Japanese Government found that the system had led to:

- An unhealthy lack of competition among care providers, so the Government realised the need to promote a vibrant, competitive market to improve quality;

- a hesitancy among low-income groups to participate and the middle- and high-income group not being able to access any subsidy from the system; and

- an overreliance on the health care system by those who could not get access to social care, leading to an increase in health care costs and a decrease in the quality of life due to extended stays in hospital.

At that time, the main issues for Japan were the increasing need for long-term care for the elderly due to a rapidly ageing society, and the fact that greater numbers of women were working outside the home.[134]

In 2000, Japan introduced a long-term term care insurance system. Under this new system, national insurance system is used to cover the care for the elderly and those aged 40 and over have to pay a premium on their tax. In addition, an eligibility test has been put in place to ascertain whether a person can access funding. Depending upon a person's level of need, there is a payment ceiling. Within this payment ceiling a person has the freedom to select the services they want. There is a co-payment system which equates to about 10-30 per cent of the cost, depending on the size of a person's income with higher earners paying a higher percentage (capped at 30 per cent) of their income for their care needs. The size of the long-term care insurance cover is about ¥12 trillion (approximately £80 billion), of which half comes from the tax and half comes from the insurance premiums.[135]

In 2021 the Government faces some difficult issues:

- In 2000 the increase in the tax premium for over 40s was the equivalent of £20 per month, however over the past 20 years it has doubled to about £40 per month, which might not be sustainable.[136]

- The workforce: the working age population in total in Japan has decreased by 40 per cent in 30 years, because of the change in the population structure. Compounding this issue is the high turnover rate among long-term care staff of about 20 per cent per year.[137] To try to combat this, the Japanese Government has introduced a scheme to increase the wages of care staff, but that is not proving sufficient, so there will need to be a focus on improving the working conditions. For example, by implementing a better career structure and reducing the burden of working unsociable hours.

- Much like the UK, Japan wants to increase the proportion of people accessing domiciliary care rather than residential care. There has been a great increase in the proportion of people receiving care at home (67 per cent in 2000 to 83 per cent in 2020), and the Government wants to increase the percentage even more dramatically. This is because the Government believes that care at home allows people to age in place and is more cost effective than residential services.

- Dr Suzuki's opinion is that the Japanese Government will have to start considering a cash benefit for family carers such as that introduced in Germany.[138] This idea was rejected by Japan in 2000, because it was thought that it would tie female family members to staying at home.

- There needs to be a greater focus on the use of data and science to inform care practice. This is necessary to improve the evidence-based nature of care and the cost-effectiveness of the services in order to secure the sustainability and resilience of the system.

Japan also has a very interesting hybrid system of care, which is used especially in rural areas where there still exists a very strong cultural context that the children should be taking care of their parents. People being cared for at home can access short-term stays at a care home to give up to two weeks of respite for their family carers.

5.4. The proposed tax-based system of care funding

5.4.1 Introduction

The adult social care environment has changed in the five years since the implementation of the Dilnot Commission's proposals were 'postponed' in 2016:

- Perceptions of a crisis in mainstream social care have deepened;

- many local authorities with adult social service responsibilities are in dire financial straits;

- Covid-19 has raised the profile of mainstream social care as a vital part of the national infrastructure; and

- there is increased recognition that more spending on social care could relieve pressure on the NHS.[139]

PPP considers that Dilnot's analysis was cogent, in that social care is, at present, a largely uninsurable risk which the UK market cannot accommodate adequately. By contrast, countries such as Japan (see case study 5.3.3.1), Germany and Israel have embraced a system wholly or partially supported by state-backed insurance schemes.

The main difficulties with the proposals put forward by the Dilnot Commission were:

- The two-pronged approach of threshold and cap was hard to explain in simple terms;

- the complexity and costs of administering the lifetime care cost cap;

- the unequal geographical distribution of benefits. The box below (Figure 5.4.1.1) shows that in general terms the North of England would have benefited from the upper asset threshold (because of lower house prices), and the South would have benefitted from the lifetime cost of care cap (because care costs are higher in the South);

- the complexity involved in discounting hotel/accommodation costs, which are an essential part of quality care;
- the need for constant review of the cap and asset limits; and
- the threat to the stability of the care providers, especially in less affluent areas in the North of England due to the payor shift.

Unequal geographical distribution of benefits - Under Dilnot

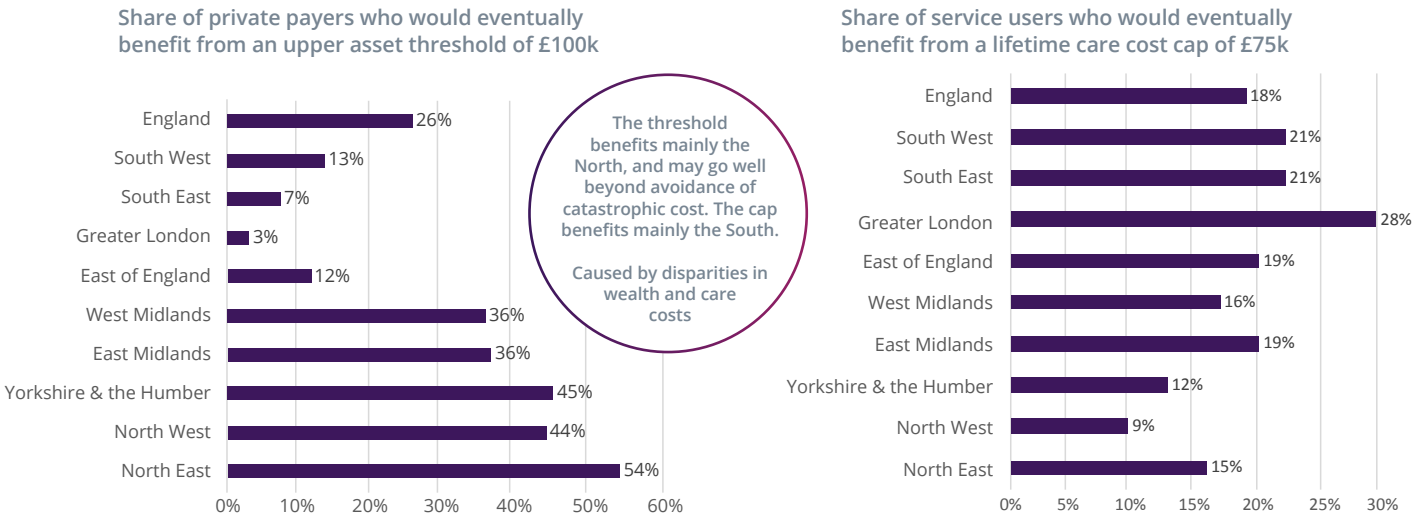


Figure 5.4.1.1 Unequal geographical distribution of benefits under Dilnot's proposed funding system.

The payor shift was not widely discussed at the time of the commission's proposals: providers of social care who are dependent on private payers' income as part of their business model would have suffered a great loss in income, and their business models would have become unsustainable. Since 1993, when local authorities were given responsibility for funding long-term care, the discrepancy between the fees paid by local authorities and the fees paid by private self-funders has grown. There is now a two-tier system in which private payers pay substantially more than the local authorities for effectively the same standard level of care. This is noted in the *Competition and Markets Authority* report of November 2017, which found that local authorities were paying less than the cost of care, and private payers were paying on average 41 per cent more than statutory authorities for basically the same service.[140] If the Commission's proposals had been implemented, they would have resulted in many private payers becoming supported by the state at much lower fee rates, and the impact would have been catastrophic for care home providers.

5.4.2 The funding proposal

PPP commissioned LaingBuisson to design a funding solution to legislate for the state funding of care for older people that had fairness at its heart.[141] The aspiration was to propose a system that would be fair across the generations, fair in the balance between what would be expected from individuals and from the state and fair across different parts of the country. Above all, it had to offer stability for commissioners and providers of care and be flexible to local

conditions, while also being able to gain support the public and from across the political spectrum. The solution had to balance the respective responsibilities of the state and the individual in funding long-term care (particularly for property owners) and the level of state funding for people with or without resources of their own. The solution proposed at the roundtable by William Laing, Founder and Director of LaingBuisson, seeks to mitigate the issues outlined above and is called the personal asset protection (PAP) system.

Under the PAP system, when an individual has spent a certain percentage of their assets on care, they qualify for local authority funding in the ordinary way if they meet the eligibility criteria. The local authority pays for a person's long-term care costs once they have spent a specified percentage of the value of their assets, as valued at the time they first accessed care. The system is easy to understand, less complex to administer, more equitable, and the payor shift threat to providers is somewhat mitigated.

Most of older people's assets are in the form of capital bound up in property. If the level were to be set that a person were to be eligible for local authority support when they had spent 30 per cent of their assets (leaving 70 per cent intact), then the modelling (see 5.4.2.2) shows that the total net cost to the taxpayer would be just under £2 billion.[142] The lower the percentage of assets to be used up before local authority funding kicked in, the more expensive it would be for the state. The higher the percentage of assets to be used up before local authority funding kicked in, the less expensive it would be for the state.

	Additional PAP net cost to councils (after receipt of user charges) of residential and nursing care for older people	Additional cost of replacing providers' lost revenue from payor shift	Central Government 'clawback' from unpaid attendance allowance	Total additional net cost to the state/taxpayer
PAP rate	£m	£m	£m	£m
85%	2,411	842	-327	2,926
80%	2,077	728	-282	2,524
75%	1,774	622	-241	2,155
70%	1,506	529	-204	1,830
65%	1,271	447	-172	1,545
60%	1,063	374	-144	1,292
55%	881	310	-119	1,071
50%	720	254	-97	876

Figure 5.4.2.1 How much the Personal Asset Protection system would cost.

The modelling shows that if the rate were set at 70 per cent (i.e. leaving 70 per cent of a person's assets intact), there would still be some unavoidable inequality across the regions in terms of who would be able to access care (see Figure 5.4.2.2), but it would be less pronounced than in the Dilnot recommendations. The slight benefit would be to people requiring care in the North West and North East of England.

Distribution of 'PAP' beneficiaries by region

Beneficiaries of PAP are biased to the North, but more evenly distributed by region than Dilnot.
Share of private payers who would eventually benefit from PAP at 70 per cent

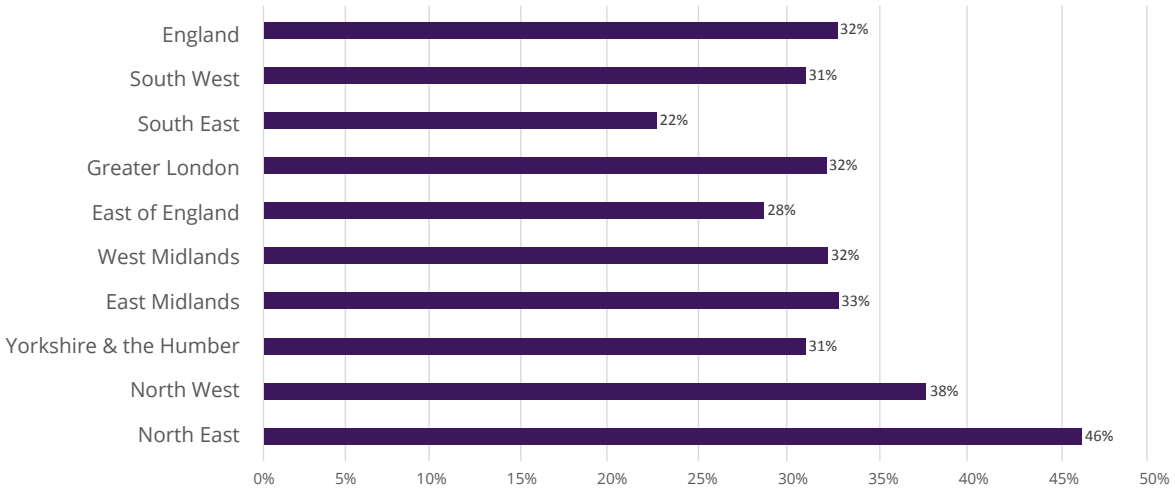


Figure 5.4.2.2 Distribution of PAP beneficiaries by region.

In terms of the effect on the profitability of care providers, the initial modelling shows that the effect of the payor shift would be less dramatic than the Dilnot Commission's proposals. Any decision on the funding model should take the payor shift into account to ensure that the providers of adult social care would remain sustainable under this new funding system.

PPP recommends this funding solution to the Government at a rate of 70 per cent PAP as modelled above. It should be noted that the £2 billion figure quoted above does not factor in consideration of the full extent of extra funding needed to address other bigger adult social care long-term funding issues. The £2 billion quoted could be raised by several billion pounds depending on the level of funding, which it is decided should be allocated to ensure a modern, well-funded system. The increase in government spending required was calculated by the Health and Social Care Committee in October 2020 as £7 billion for social care.[143] This is the level of extra funding that would be needed if there was the intention of i) re-establishing the level of access to state funded services compared with before the financial crisis, ii) delivering a new pay and free training deal for the social care workforce to address the issue of the staff turnover rates, and iii) of ensuring funding to fully deal with the cross-subsidisation from private to public.[144]

In summary, the advantages of the PAP system, as an alternative to any combination of threshold or cap, are:

- The concept is simple to understand;
- it delivers benefits (in terms of peace of mind) to the full range of property owners;
- there would be minimal change to the current means-testing regime;
- the geographical distribution of benefits under the PAP system would be more equitable than under a threshold extension and a lifetime care cost cap;
- the propensity of individuals and their financial advisors to 'game' the system by divesting property assets would be no greater than the current incentive to divest property assets to circumvent the £23,250 threshold;
- the opportunities for developing new long-term care insurance products around the PAP system would be at least as great as building them around combinations of threshold and cap, and probably greater; and
- there is less potential for criticism of the new system as opposed to the Dilnot recommendations. For example:
    - The PAP system does not split care and accommodation costs; and
    - there is no need for annual upratings for inflation (although the PAP percentage could be varied if desired).

5.6 Conclusion

The future funding of care for older people in England is one of the major challenges for the Government. A system based on the proposed PAP system would deal with the many of the inequity issues in the current system. It should be supported by other initiatives, such as greater co-ordination of resources across health and social care and the facilitation of mechanisms for people to use their own funds at their own discretion. If this issue could be agreed across the political divides, it could give great impetus for new initiatives to build a care system fit for the 21st century.

5.7. Recommendations

1. There must be some recognition of the fact that there is inequity between the funding of care of people with what are perceived as healthcare issues (e.g. cancer) and those with social care issues (e.g. dementia).

2. A new funding agreement has to be agreed across party political lines and satisfy the needs of commissioners of care, the people who require care and support, and the providers of that care.

3. Funding for care for working-age adults should be from a separate pot and split out from that for older people. It should form the basis of a separate discussion.

4. There has to be greater focus on increasing access to information, sharing funding across health and social care more effectively and increasing access to respite care.

5. The new system should be based on tax revenue and should give people the opportunity to enhance their care environment from their own assets or insurance schemes.

6. The various funding pots should be rolled into one and the system of personal budgets should be enhanced, so people can use the funding available to them to fund the care they want.

7. Various schemes such as equity release and enhanced property rental schemes should be promoted as ways for people to fund the enhanced care at their own discretion.

8. There should be a market created for insurance options for long-term care, which would be totally elective, as a way for people to fund the enhanced the care they want to receive.

9. Legislation should be enacted for a new system for regulating the provision of state funding for older people requiring care. The new system should be as simple as possible. The proposal put forward is called the personal asset protection (PAP) system. The system would set a percentage of a person's assets which should be used up before long term care funding from the state could be accessed. The relative simplicity of the system, and its relative equity to different sectors of society, should mean that it gains acceptability across the major political parties and across a wide spectrum of the electorate.

6: Infrastructure

The infrastructure needed for care needs to fit the new models of care recommended in this section. It depends on budgets being managed at a local level for maximum local benefit and a focus on ensuring people have choice about where they choose to receive the care and support they need, be that in their own home, a new home, a residential home or in the community. The planning regulations must facilitate this choice and ensure consumer choice as well as protection. This requires strong national guidelines and empowerment of local bodies, including the new Integrated Care Systems (ICSs) and local planning bodies. There are material actions the Government can take to build a strong infrastructure for care, which are explored below.

6.1 Introduction

To provide the best wellbeing infrastructure possible for older people, there needs to be a renewed focus on the infrastructure available for people to live with the wellbeing facilities and care they need. This could be in their own home, in a new modified home or retirement setting or in a care/nursing home. To make the choice of where to live, it is essential that people have a clear understanding of the issues, the financial implications and choices they need to make, which are future-proofed as much as possible.

PPP assembled a group of experts to discuss these issues. They considered how the environment and infrastructure for social care in England could be changed to give older people the appropriate choices. This section does not purport to be comprehensive: it is set out in such a way as to promote discussion while focusing on the potential for retirement living/extra care housing, ageing in place (i.e. in one's own home), moving to a new home to accommodate later life living and care homes.

The subject-matter specialists at the roundtable took the discussion in an unexpected direction. Rather than discussing the infrastructure options in greater detail, the emphasis turned to the need for local autonomy and budgetary control to influence the care and wellbeing infrastructure of a local footprint. The discussion became focused on the benefits of an integrated health and care system as the way to ensure that the infrastructure in a locality works to promote healthy living and the most economically viable solution for a culture of wellbeing. This builds on the integration narrative expounded earlier in this paper and sets the tone for this discussion on the health and wellbeing infrastructure.

6.2 Funding/integration

Cllr Ian Hudspeth, former chair of the Community Wellbeing Board at the Local Government Association, gave a very strong message that the infrastructure of care needed to be considered at a local level. By ensuring shared budgets across health, social care and public health, a locality could

promote a the preventative agenda and community wellbeing. The advent of ICSs potentially gives a chance to do this, although the governance systems suggested in the recent white paper might need to be reviewed, if ICSs are to ensure that the infrastructure in their footprint is fit for purpose.

There needs to be a balance in any locality in the infrastructure for older people between:

- The provisions of retirement housing;
- ensuring that people have the ability to age well in their own home (housebuilding programmes and adaptations);
- access to care facilities (care homes, home care and schemes such as Shared Lives or Care Rooms);
- access to health facilities; and
- community and public health services.[145]

With an increasing emphasis on a community and prevention approach, there is the opportunity for an empowered ICS to oversee what is the right provision in terms of health, care and housing within its own footprint. Ian was keen to stress the power an ICS would have, were it in control of a budget that combined health, social care and public health funding, and their respective capital budgets. With such a base in place, they would have the ability to influence an infrastructure based around individual wellbeing. They would be in a position to commission multi-use community facilities (maybe on the model of the Bromley-by-Bow Centre) as well as housing and housing with care, which would cater for its local older population.[146]

If an integrated care policy could be put in place, it would have the capacity to save money for acute NHS services. (see case study 5.3.2.1 on the Irish care funding system above) The rationale is that if health and care services were based on promoting wellbeing, peer support and preventative community services funded from an integrated health and care budget, they could capture the value created by care services, which, in many instances, at present, is captured by the health services.[147] If a truly integrated care and health economy can be put in place in a locality, then the money saved and the value created by better preventative care can be used constructively in other parts of the health and care system. In short, if one body was overseeing the preventive social care and acute health intervention budget, then money saved on acute provision could then be put to work in community services. This money saved could also be put to work in creating a housing provision for older people that focused on joined-up health and care facilities housed in public buildings, with the health and local authorities working as one.

The basic principle in building the infrastructure of a locality is that if people could live a healthy lifestyle and had access to a safe secure home that matched their needs, then the individual and the community as a whole would benefit. In a truly integrated local structure, there would be the possibility for health and care to link with public health to make planning decisions based on provision of a healthier, more wellbeing-focused environment. The issue then to resolve is how the centralised nature of the NHS provision would be incorporated into this integrated structure, and how neighbouring localities would benefit from shared resources. These two issues would have to be part of the discussion when discussing a truly integrated health and wellbeing infrastructure.

6.2.1 CASE STUDY

Shared Lives – the way to greater personalisation of the care infrastructure

The care a person accesses should be tailored to their specific needs. Shared Lives is one of the most practical approaches the care and health system can offer to make personalised care a reality. If fully integrated at a greater scale into the health and care infrastructure, it would lead to many better outcomes and overall savings in the care and health system.

15,000 people already live with or regularly visit their chosen Shared Lives carer, all across the UK. The Shared Lives scheme has a 40-year history as a form of social care. The scheme enables people to live as part of a supportive household rather than living in a care home, or to visit their Shared Lives carer, rather than visiting a day centre or having respite breaks in a residential service.

England's 125 local Shared Lives services have developed a reputation as one of the most personalised forms of care, with the CQC consistently rating it as the best-performing model of regulated social care. Although it is a living example of the extraordinary health and wellbeing outcomes that personalised care can achieve, there are many areas that are still to realise the full benefit of Shared Lives. At present, all local Shared Lives services are members of Shared Lives Plus, the charity and membership body, which provides guidance, resources, quality products and communities of practice.

The Shared Lives carer

Shared Lives carers are recruited and trained through an in-depth three-to-six-month approval process. These carers are paid and work under contract to a local CQC-registered Shared Lives scheme, whose registered manager is ultimately responsible for the safety and quality of each support arrangement. Each support package typically costs the commissioner about £400-650 a week (including about £100-150 for the organisation's management fee and £250-450 for the care payment to the Shared Lives carer for a live-in arrangement, depending on the level of support needed). This is paid for through council social care or NHS continuing healthcare budgets. In live-in arrangements, the individual also pays for their accommodation from housing benefit and usually contributes to household bills from their disability benefits. Funding for a Shared Lives arrangement could be via Continuing Healthcare (CHC), personal health budget (PHB), Section 117 or spot purchased within other contract budgets. They may be fully health funded, or joint funded with social care. [148]

The Shared Lives arrangement

A Shared Lives arrangement starts with matching. The Shared Lives carer and the individual looking for support get to know each other and may opt for a trial period first before deciding that the match will work. It is always their choice. The local scheme supports and monitors the match and finds a new support arrangement if the match comes to an end.

The individual either moves in with their chosen Shared Lives carer or visits them regularly. The Shared Lives carer treats the individual as 'one of the family', involving their family and friends to grow the individual's informal support network. A Shared Lives carer supports no more than three people at any one time but can provide short breaks or day support to more than three people over the course of a week.

Case study

The value of the Shared Lives scheme is demonstrated by the example of William, an elderly man, who had a fall. This was most likely prompted by other health issues, which included early onset of dementia. When he was ready to be discharged from hospital, his family felt unable to care for him and the discharge team thought Shared Lives would be a good option for him and allow him to retain his independence at home. They planned an initial four-week period for William to fully recuperate from his fall, with a possibility of extending to a full-time arrangement.

Thanks to the Shared Lives scheme, a carer could take the referral at short notice and met William at the hospital, where they got on well and agreed that the arrangement would go ahead. William moved in to a safe, caring and supportive home close to his family, and began to receive the support his family were not able to provide. The support from the Shared Lives team and the carer's skills and willingness shows that these types of arrangements can work for rehabilitation and respite.

Potential barriers

Setting up a Shared Lives scheme and then setting up individual arrangements takes time and commitment. Clinicians can be initially reluctant to refer to the service, and quick to give up if initial referrals do not result in support arrangements. As such, referral processes and care pathways need to be adjusted to include the Shared Lives model and the matching process. The sector has just developed online recruitment and training approaches that may help to streamline these processes in future. The local authority, NHS and partners should invest in expert advocacy and brokerage support, training, breaks and back-up for Shared Lives households to enable them to care safely and sustainably for people with significant or unpredictable support needs. It is imperative that senior local authority leaders invest time in internal awareness and have a desire to implement new models and to move to a more 'personalised' and 'asset-based' culture of care.

To overcome the barriers, there needs to be a full package to explain and embed the Shared Lives way of working. The initial investment will bear fruit many times over.

6.3 Retirement Living and Housing with Care

The roundtable dedicated a large portion of its time on retirement living (normally defined as housing with either no (or limited) support available and housing with care (retirement villages and extra care). In the latter, support and personal care, and sometimes nursing care, are provided on a care village or apartment block basis. The major contributor to the roundtable on this issue was Jane Ashcroft CBE, Chief Executive of Anchor Hanover, which is England's largest not-for-profit provider of housing and care for people in later life.

There is a growing evidence base that good quality retirement housing with varying levels of support can help people live longer, happier, healthier lives and, in particular, reduce the demand on the NHS and social care. Research carried out by the Extra Care Charitable Trust with Aston University from 2012-2018 found that for people who live in retirement communities:

- NHS costs were reduced by 38 per cent;
- unplanned hospital stays were reduced from eight to 14 to one to two days;
- there was:
    - a 46 per cent reduction in routine and regular GP visits;
    - a 14.8 per cent reduction in depressive symptoms in 18 months;
    - a 23 per cent decrease in anxiety symptoms;
    - a 24 per cent increase in autobiographical and 17 per cent increase in memory recall tests;
    - a significant improvement in the level of exercise done by residents; and
    - an increase in walking speed and a reduction of falls over the first two years
- the increase of frailty was delayed or reversed in residents; and
- 86.5 per cent of residents were 'never or hardly ever' lonely.[149]

These are surely results that mean that that good-quality retirement housing, with varying levels of support, should be one of the major infrastructure priorities in planning for a healthy cohort of older people.

During the past 12 to 18 months, interest from older people in Anchor Hanover's retirement housing options has been invigorated, because lockdown has focused people's minds on the need to limit the effects of isolation. This led to a "a huge uptake of interest in retirement housing across all types of tenure" during the easing of lockdown on the summer of 2020. These types of tenure include:

- Social housing, where Anchor Hanover operates generally with local authorities that nominate people to use Anchor Hanover services or in its own private facilities;
- new independent living developments; and
- extra care services, where people purchasing apartments, usually on a long-term leasehold basis or in a shared-ownership model, can have access to care.[150]

From experience with people moving into independent living developments, Anchor Hanover realised that the most important aspects people value in retirement living are the ability to downsize, the access to care and support when needed, and access to an outdoor space without responsibility for its upkeep.

There are various sectors of society for whom a retirement living complex can be especially attractive, and Jane was keen to highlight that it is a very workable choice for people who do not have a family or whose family are not available for whatever reason to be on hand to care. This echoes the message of Ageing without Children (see case study 6.3.2). Moreover, many people do not want their family to become their carers, so retirement living with care available becomes a very attractive option. The previous section on the funding of care highlighted that when people step out of the workplace, or reduce their economic activity, to care for family members it has a detrimental effect on the economy as a whole. If this can be avoided, then the knock-on effect of a good retirement housing infrastructure is that the local economy benefits.

There is great potential for specialist retirement housing to serve underserved sectors of the community as a way to deal with the inequities in health and care provision. For example, Anchor Hanover was selected in March 2021 to work in partnership with Manchester City Council to deliver the first purpose built extra care housing facility in the UK for older people from the LGBT community. This will be an affirmative scheme where 51 per cent of the people who live there will come from the local LGBT+ community. This would have been unimaginable 15-20 years ago, and Anchor Hanover, like other housing organisations, is in discussions with other communities about the potential for specialist defined housing to serve their needs. If one of the Government's priorities is to deal with the inequalities in the health and wellbeing among specific communities, this is one way this agenda could be furthered.[151]

Anchor Hanover has typically found that it is essential to offer as much choice as possible to people, whether that is choice of tenure and/or choice of care and support package. They see huge opportunities for this market to grow but are concerned at confusion within the planning and regulation of such sites. Jane asserted that there are opportunities to remove some of the barriers that are intrinsic in existing planning systems that were enacted in the post-war period. Retirement housing options are an underused resource in England, and one of the reasons for this is the confusion in the planning regime. Retirement housing straddles two planning use classes: C3, which is the class for regular residential developments, and C2, which requires some kind of care to be provided on site.

Savills' report on *Retirement Living* in June 2019 states:

"Guidance on the amount and type of care needed to qualify as C2 is inconsistent across the country, leading to uncertainty over whether a potential retirement living scheme will be viable. In London, guidance is clearer, in that C2 developments are expected to provide both care and affordable housing, putting them at a disadvantage to C3 schemes.

Clarity on what level of care is required on C2 developments, perhaps through an update to National Planning Practice Guidance, would reduce this uncertainty and could unlock more retirement housing development, particularly if it levelled the playing field for schemes in London".[152]

The planning system in some ways actively militates against the provision of this sort of housing because it falls between the gaps of C2 and C3 planning permissions. Consequently, there have to be detailed conversations about a minimum number of hours of care per resident that need to be delivered for a site to be classed as housing with care. This legislation is meant to serve care homes rather than residential communities, and thus needs updating.

Anchor Hanover is keen for greater consumer protection especially regarding event fees. These are fees charged by the freeholder, the developer, the operator or the managing agent of the retirement sites at the time of certain events such as sale, sub-letting or change of occupancy: they are sometimes known as exit fees, transfer fees, deferred management fees, contingency fees and selling service fees.[153] They are often not as transparent as they should be and lead to great confusion for people purchasing retirement living properties on a long leasehold arrangement.

The LaingBuisson Retirement Housing Report of 2020 reports that the Government welcomed the findings and recommendations of the Law Commission's 2017 Report *Event fees in retirement properties*.[154] The report made recommendations on legislation required to clarify the issue of event fees and to introduce greater transparency, but no legislation is as yet forthcoming. It is widely thought that the way New Zealand legislated for these fees in 2003 is the model that the UK Government should adopt, to ensure transparency for people purchasing retirement living homes.

6.3.2 CASE STUDY

Ageing Without Children

There are more than one million people over 65 in the UK who have never been parents. This number is set to rise to two million by 2030[155], and half of all people over 75 live alone. More people than ever before are getting divorced in later life or grow old, never having been married or with a partner. The organisation Ageing without Children (AWOC) has been set up specifically to campaign on this issue and support people who are ageing without children.

Even for those who are parents, there is an issue where children have chosen to live in different parts of the country or even in another country than their parents, and there are also people whose children have predeceased them or who may still require significant care themselves. In addition, about 90 per cent of LGBT people and 85 per cent of people with disabilities do not have children.[156] These cases are hidden, and people without children are often unable to access the unpaid care on which people who have children rely. The growing number of people ageing without children suffer due to isolation, lack of support and the consequent health deterioration which leads to greater need for health or care intervention. Many people are unaware of this issue before they are faced with the facts above.[157]

The care system in the UK relies on the goodwill and dedication of family members to both advocate for and carry out caring duties, seemingly as a default approach. When that family support is absent for whatever reason, then the state or the local authority has to fill the gap, although those ageing without children have experienced confusion and even disbelief from health and social care staff when they have presented as needing support. In 2016 AWOC was set up to help people deal with this issue, and in early 2020 applied to the Charity Commission for registration as a charitable incorporated organisation.

Since the start of the Covid-19 pandemic its work has brought into sharp relief the fact that, without an organisation to advocate for them, people ageing without children can be dangerously marginalised, excluded and isolated. A study in 2012 identified the issue that older parents in England had higher chances of at least weekly face-to-face social contact than their childless counterparts.[158]

The purpose of AWOC's work is therefore to:

- Be a safe place where people ageing without children can come to share experiences and ideas to help with practical problems;
- provide peer support and understanding for people ageing without children from others in a similar situation;
- influence local and national planning and policy on ageing so that the experiences of people ageing without children are taken into account and that policy and practice change to meet their needs; and
- identify solutions/services that could help people ageing without children to have improved health and social care outcomes.

The organisation has written a guide to setting up AWOC groups to help individuals and communities work with ICSs and the health and care system to establish local groups supported by a central office that

- Promotes the groups through its website and networks:
- provides accessible web resources and contact information;
- provides training and support to volunteer group leaders;
- provides a resource pack to help volunteer group leaders;
- maintains regular contact with groups and acts as a conduit of information, sending out updates about issues relating to ageing without children and gathers feedback; and
- co-creates marketing materials to promote their group in GP surgeries, day care centres, libraries, council offices, cafes and community centres.

The York AWOC group has been running for five years. In that time the group has created training tools to use with local organisations within the health and care system, both commissioning and provision. Its research on how people ageing without children have been affected by Covid-19 has highlighted the growing problems of marginalisation and isolation faced by this group.[159] The group in Bradford has successfully lobbied for ageing without children to be specifically included in post-Covid policy work on ageing and for Bradford NHS trust to provide training on this issue to all staff. There are also active AWOC ➤

groups in Leeds and East Lindsey.
In 2017 the number of older people in need of care outstripped the number of adult children able to provide it in Britain for the first time. By 2030, there will be at least two million people over 65 in England without a child to care for them. Local authorities and ICSs ignore this issue at their peril, and AWOC will have an increasingly important role in the integrated services to ensure that older people ageing without children do not fall between the gaps.

6.4 Care homes

The aspiration of increasing access to retirement living with care is not an attempt to replace care homes: it is about having a range of housing with care options available in community. Anchor Hanover asserts that its care homes are an essential part of its offer, but currently 10 per cent of its provision is in care homes with 90 per cent being in retirement communities. This is a ratio that could guide thinking on planning of care at a locality level. Greater access to retirement housing would mean that care homes would then be freed up to be the best that they can possibly be. It would allow them to be fully focussed on people with the needs that can best be met within the environment of a care home, many of whose needs relate to their living with dementia.

Before the pandemic, there was optimism for the potential for the UK's care home industry: occupancy was at 90 per cent and the sector was growing. Knight Frank called for a clear need for investment in new stock to satisfy investor demand.[160] It estimated that £15 billion would be needed to upgrade existing care homes which risked closure if they were not updated.

Now, after the pandemic, occupancy rates have fallen to 79 per cent and the role of care and nursing homes has never been under more scrutiny.[161] Care homes were not a major point of discussion at the roundtable. However, mention was made of the need to incentivise care providers to upgrade existing stock and for planners to facilitate the building of new care homes to a new specification. PPP feels that it is too early to fully review the future of the care home sector at the moment, as it is still recovering from the effects of the pandemic. However, when the time is right, there needs to be a review of care home sector provision and its full value in an integrated system of health and care.

6.5 Housebuilding and adaptations

The housing experts at the roundtable discussed the complex issue of housebuilding, and there were mixed opinions on whether housing should be focused on being adaptable as people aged in situ, or whether people should move to accommodate their needs as they grow older. It was acknowledged that moving becomes more difficult as a person grows older, and that there needs to be a dual approach of building specifically for older people and providing more efficiently for the possibility of adaptations.

If a person wants to adapt their existing residence to accommodate their needs as they age, the main incentive the Government offers is the VAT relief available on certain types of adaptation. However, the guidance is quite restrictive and should be relaxed.[162] For example, at present the following work is not available for VAT relief:

- The construction of a downstairs bedroom or adaptation of an existing room to form a bedroom;
- The refitting of a kitchen; and
- The extension or adaptation of the property to provide a conservatory, carer's room, office or living room.

These proscribed adaptations are ones that could enable a person to adapt their existing home if they wanted to age in place. There is an argument that there is greater ability to amend VAT regulations now that the UK is no longer part of the European Union. Some participants urged the Government to take this opportunity to amend the VAT regulations to incentivise adaptations to houses where appropriate to accommodate later life living.

Now, more than ever, there is greater possibility of remaining in one's own home with access to technology such as environmental monitoring, voice activated and remote health monitoring tools. These are already being prioritised in certain areas, and their widespread adoption and funding would have significant impact in allowing people to age in place with as little disruption to their lives as possible.

A surprising interjection in the discussion was by Alex Morton, Director of Policy at the Centre for Policy Studies, who advocated for the building of more bungalows. He recounted his surprise when he was involved in housing policy, that many people he met complained that there were not enough bungalows on the market.[163] This is mainly because they are seen by developers as a poor use of space in general developments and also in retirement living options. Bungalows offer ideal potential for later-life living and should be part of an overall legislative push to create housing which older people can adapt to their needs.

6.6 Conclusion

For the best provision of an infrastructure that serves the health and wellbeing of a local older population, the integration and joint planning of health and care needs to be an urgent priority. This joint planning would allow provision of the appropriate infrastructure, employing all potential sorts of housing with care options to provide for the community. High on the priority list should be the provision of retirement housing, both with and without care facilities. This would allow people to find the level of community and social care support they would need to have the best opportunity of ageing well. During the pandemic, the isolation of older people has been a major health concern, and the provision of better retirement living options in community-based facilities would mitigate this issue. There needs to be a change in planning regulation and in the regulation of care in retirement living communities, because the current legislation is out of date and is an impediment to the ability of this sector to reach its full potential.

This focus on retirement living options should not be at the expense of care homes that require incentives to invest in upgrading the building stock available. The upgrading and building of appropriate new facilities are needed to ensure that the care home of the 21st century plays its role in society in caring for those who cannot be supported sufficiently in their own home or in a retirement setting. In addition, people should be encouraged either to adapt their own home to their needs or downsize to a property that affords them the opportunity to live as independently as possible. The key is that there should be options for later-life living, which people can choose as appropriate to their health and wellbeing situation and their continued healthy living.

6.7 Recommendations:

1. Budgets and planning for health and care should be delegated as much as possible so a locality or ICS footprint can design its health and wellbeing infrastructure according to local needs and priorities.

2. There should be a new planning class for retirement living developments which at the moment fall between C3 (normal residential developments) and C2 (developments with a care element). The classifications are outdated and require modernisation. This will have to be co-ordinated with new care regulation relating to retirement communities.

3. The Law Commission findings and recommendations on events fees should be the basis of consumer protection legislation to create more transparency in the market.

4. There should be a Government-led programme to help/incentivise people to downsize and/or adapt their homes as they grow older. Part of this could be amendment of planning regulation to accommodate the building of more bungalows, which allow people to age better in place.

5. People should be given greater incentives to modify an existing home by increasing the scope of VAT relief on a further range of structural adaptations, which could promote aging well in situ (There is some suggestion that having left the EU, the UK is now in a position to amend VAT regulations more easily).

6. Care homes should be incentivised to upgrade services and build new stock as part of the development of the health and care system.

Case Study List

Acknowledgements

Roundtable and Case Studies

Thank you to all who joined the report co-chairs for the series of roundtable discussions, hosted to debate the themes of this report. Contributors' insights have proved invaluable to its direction and outcomes. The report recommendations are a direct outcome of the concerns, suggestions and ideas generated in those sessions. All who attended are welcome to join for future discussions.

Thanks also to those individuals and organisations who submitted case studies. The evidence provided has helped steer and substantiate the recommendations made in this report.

Casson Consulting

This report was written, the interviews conducted, and the case studies analysed by Daniel Casson, Managing Director at Casson Consulting.

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134. https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS?contextual=default&end=2016&locations=JP-GB-IT-RU-FI&name_desc=true&start=1960&view=chart _ accessed 1 June 2021. People over 65 years old now make up 29 per cent of the whole population in Japan, as opposed to 8 per cent in 1950 and 16.7 per cent in 2000. In the UK, the over 65s represent about 18 per cent of the total population.; In 1973 one in two Japanese women worked outside the home, whereas in 2020, 71 per cent of women work outside the home.
135. It is not clear from the transcript nor the PowerPoint presentation whether this ¥12 trillion was the size of the insurance fund or was the combined insurance and state funding. The transcript states: "And the financial scale of the long-term care insurance is about 12 to trade union [12 trillion yen], which is about 80 billion UK pounds, British pounds. And the half of these 80 billion UK pounds were cut, were coming from the tax money and half are coming from the in the premium insurance premiums."
136. Note that in Germany where there is a state funded system, the Government is considering reform to increase the pay of care workers by contributing one billion euros to Germany's long-term care insurance. Care homes and care service providers would have to pay their staff a certain minimum salary agreed with trade unions from September 2022 to be still allowed to settle their accounts with the health insurers, according to the agreement. See https://www.investing.com/news/economy/german-government-agrees-on-reform-for-care-homes-2518771 _ accessed 1 June 2021.
137. In the UK the turnover rate was calculated at 32.2 per cent in 2018-19 _ https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf _ Accessed 1 June 2021.
138. Source for DR Suzuki's comment not found.
139. https://lgiu.org/wp-content/uploads/2020/02/LGIU-State-of-local-government-finance-2020.pdf – accessed 14 June 2021.
140. https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report _ accessed 7 June 2021. The report is solely on care homes; however, the cross subsidy also exists in the home care market.
141. https://www.laingbuisson.com/about-laingbuisson/ _ accessed 7 June 2021.
142. This £2 billion includes an additional cost of approximately £500 million to replace providers' lost revenue from the payor shift i.e. an additional net amount to be allocated to social care to address the need for local authorities to be able to pay providers sustainable rates for care.
143. To find out more information about what the Shared Lives Carer roles involves and getting involved in your local scheme, visit https://sharedlivesplus.org.uk/.
144. https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/120204/mps-call-for-7bn-annual-increase-in-social-care-funding-as-a-starting-point-for-reform-doing-nothing-no-longer-an-option/ _ accessed 7 June 2021.
145. The payoff for investing more heavily in social care would be to allow social care to focus more on preventative care, thus saving the NHS and society money.
146. https://sharedlivesplus.org.uk/ - accessed 10 June 2021; https://carerooms.com/about/ – accessed 10 June 2021.
147. https://www.bbbc.org.uk/ _ accessed 12 June 2021.
148. Value creation and capture are well versed theories in business, and there is very little research in health and care on how value created in one area is often captured in another area. To illustrate this, if a community care service prevents carer deterioration by supporting the carer, then the real value is captured by the health services that do not have to deal with a deterioration requiring acute intervention and respite care for the cared for person. This is an area that requires further work in the health and care sector in the UK.
149. https://www.extracare.org.uk/media/1169231/full-report-final.pdf _ accessed 7 June 2021.
150. For these latter two the price points vary from £180,000 up to about £750,000.
151. https://www.england.nhs.uk/ltphimenu/definitions-for-health-inequalities/ _ accessed 12 June 2021. This NHS paper labels health inequalities as "unavoidable", however health inequalities can be mitigated by positive promotion of wellbeing facilities for people in groups which are identified as having poorer health outcomes. PPP agrees with the assertion on this webpage that: "Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.", however it does not agree that these inequalities are unavoidable.
152. https://www.savills.co.uk/research_articles/229130/283708-0 _ accessed 8 June 2021
153. As defined in the Law Commission Report https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Event-fees-in-retirement-properties-summary.pdf _ accessed 11 June 2021.
154. https://www.laingbuisson.com/shop/retirement-housing-uk-market-report-1ed/ _ accessed 8 June 2021 (full report available for purchase)
155. https://ageingwithoutchildrenconsultancy.com/ _ viewed 14 May 2021.
156. https://www.theguardian.com/science/2019/mar/28/over-1-million-childless-people-over-65-are-dangerously-unsupported _ viewed 14 May 2021.
157. https://www.youtube.com/watch?v=hB60icyYN-hg _ viewed 2021; https://www.youtube.com/watch?v=V5EsxU84ay4 _ viewed 14 May 2021; https://www.youtube.com/watch?v=V5EsxU84ay4 _ viewed 14 May 2021
158. https://pubmed.ncbi.nlm.nih.gov/23033356/ _ viewed 14 May 2021.
159. https://www.yorkpress.co.uk/news/18553317.hidden-impact-pandemic-ageing-people-without-children-revealed/ _ viewed 14 May 2021
160. https://www.carehomeprofessional.com/uk-care-home-industry-facing-unprecedented-crisis-says-knight-frank/ _ accessed 10 June 2021.
161. https://www.carehome.co.uk/news/article.cfm/id/1639617/care-home-occupancy-predicted-rise-pre-pandemic-levels-2021 _ accessed 28 June 2021.
162. https://www.gov.uk/guidance/vat-relief-on-certain-building-work-if-you-have-a-disability _ accessed 11 June 2021.
163. https://www.rightmove.co.uk/news/articles/property-news/most-popular-property-types/ https://www.bbc.co.uk/news/magazine-35762512 https://www.thisismoney.co.uk/money/mortgageshome/article-3043630/Last-bungalow-home-built-2020-downward-trend-continues.html

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