Good Governance Institute

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Representing independent care providers

The relationship between the adult social care sector and ICSs: time for action?

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Good Governance Institute

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The relationship between the adult social care sector and ICSs: time for action?

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Introduction

In 2017, the Good Governance Institute (GGI) and Care England jointly published the paper *System transformation and care homes*.[1] This report explored the extent to which the adult social care sector was being appropriately engaged in the development of sustainability and transformation plans (STPs).

The report showed that there was limited evidence that STPs adequately reflected the challenges that the adult social care sector was facing at the time and argued that additional engagement across health and social care would be required in order to drive necessary improvement.

Since our report was published, the risks to the adult social care sector have only increased, with the COVID-19 pandemic, in particular, highlighting stark funding and workforce challenges. Many of the statistics associated with the sector in England make uncomfortable reading, including more than 122,000 vacancies, a turnover rate of 30.8%, a quarter of staff employed on zero hours contracts, and as many as 1.4 million older people unable to get the care and support they require.[2] Indeed, the Health and Social Care Committee in a recently published review called for an increase in annual funding of up to £7 billion by 2023–24 to prevent the collapse of the sector.[3]

As we made clear in 2017, in tandem with increased funding, greater collaboration between health and social care services will be required to begin to address these issues. It seems that most would agree and, as such, plans for the development of integrated care systems (ICSs) have continued, with recent important papers setting out proposals for legislative reform from both NHS England (NHSE) and the Department for Health and Social Care.

Recognising this, it felt timely for us to revisit our 2017 study to assess what progress had been made and what further support and development may be required to ensure that the adult social care sector is adequately engaged.

This short paper brings together our thinking around some of the key pieces of policy pertaining to the adult social care sector, as well as the learning from a series of interviews and a roundtable that GGI convened with ICS independent chairs, policy-makers and adult social care providers. Where relevant, we also present example of good practice from across the country.

Adult social care: what do you need to know?

As the English population grows and lives longer, demand for adult social care services is rising. It has been estimated that as many as 1.7 million more people will require adult social care services over the next 15 years.[4]

Those with assets amounting to more than £14,250 have to fund their own social care. Where this threshold is not met, local authorities provide funding. Over the last ten years, demand for local authority funded social care has outpaced growth in funding. Research by the Health Foundation indicates that spending per person on adult social care services declined by 12% between 2010-11 and 2018-19.[5] This, in turn, has created inequity within the system as social care providers turn to self-funders to make up the deficit.[6]

Spending on social care per person is lower in England (£324 per person) than in Scotland (£446 per person) and in Wales (£424 per person).[7]

Social care is delivered, predominantly, by private providers who are either commissioned by local authorities or funded individually. In 2019/20, there were an estimated 18,200 organisations involved in providing or organising adult social care.[8] However, as a result of declining funding and higher costs associated with delivering care, many of these providers are handing back contracts to local authorities. The Association of Directors of Adult Social Services (ADASS) has estimated that as many as a third of all providers are making a loss and warn that this might rise.[9]

The COVID-19 pandemic has also exacerbated these funding pressures. In October 2020, the Health and Social Care Committee called for a £7 billion annual increase in social care funding to prevent the risk of the sector collapsing.[10] Others, including the Health Foundation, have argued that more will likely be needed.[11]

Alongside these significant funding pressures, the sector, as with the NHS, is in the midst of a severe workforce crisis. The social care sector is a significant employer, with around 1.5 million staff involved in delivering social care in England. Recent estimates, however, suggests that there remain as many as 122,000 vacancies, a staff turnover rate of 30.8% and 25% of staff employed on zero-hour contracts.[12]

It has been estimated that, in order to keep up with demand, the adult social care workforce will need to grow by between 650,000 and 950,000 staff by 2035.[13]

Historically, adult social care services have not been engaged as effectively as they might have been in system planning initiatives such as STPs and ICSs. Our 2017 report revealed the limited extent to which STPs had involved or reflected upon the adult social care sector in their plans.[14] While progress has been made since, in researching this report we heard, anecdotally, that there is a mixed picture across the country and that there remains much to do for adult social care to be accepted on an equal basis with health.

The picture since our last report - largely unchanged?

2017

The Five Year Forward View had set out the ambition to introduce new models of care to drive integration across health and social care.

STPs were finding their feet and there was limited engagement with the care sector.

Significant funding pressures abound in the care sector. By one estimate, as many as half of care home providers were at risk of bankruptcy.

Across the sector there were 90,000 social care vacancies and staff turnover of 27%.

There was an increasing ambition to use technology to improve services and efficiency.

2021

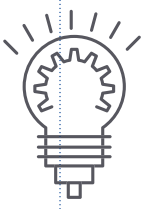
Subsequent national policy, including the NHS Long Term Plan, has reaffirmed the direction of travel for health and social care.

NHS England has set an expectation that all STPs will become ICSs by April 2021, with the recent Government White Paper looking to put them on a statutory footing.

Today, engagement with the care sector has grown, with room for further improvement.

Funding pressures remain and, in many places, have increased.

Staff vacancies have swelled to 122,000 and the turnover rate to 30.8%.



The challenges faced by the care sector are laid bare by the COVID-19 pandemic. However, this has reinforced the need to utilise technology as fully as possible.

National policy and direction of travel

The NHS Long Term Plan

The NHS Long Term Plan (LTP), published in January 2019, set out a vision for health and social care for the next 10 years. The LTP strongly emphasised the need for greater collaboration and integration between health and social care, with the government's proposed green paper on adult social care expected to provide further detail on how this would be achieved.

At the time of its publishing the LTP was criticised as a 'missed opportunity' for adult social care, with many arguing that it should have provided greater clarity as to how the sustainability of the sector would be ensured through a new funding settlement. The government's adult social care green paper is also yet to be published, despite assertions, in 2019, that it was 'ready'.

With regard to the independent care sector, the LTP specifically mentioned NHS England's Enhanced Health in Care Homes programme, which is now being rolled out across the country. This model aims to support the transition 'away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff,' through a focus on collaboration between health, social care, voluntary, community and social enterprise sectors and care home partners.[15]

There is a significant body of evidence to suggest that adoption of this model can lead to better coordinated care and improved patient outcomes. Indeed, the LTP gives the example of the Nottinghamshire Vanguard, in which those residents in care homes experienced 29% fewer A&E attendances and 23% fewer emergency admissions than a matched control group.[16] An evaluation by the King's Fund was also positive, finding that 'significant results can be visible within a few months.'[17]

Our analysis of STP and ICS planning documents reflects this emphasis, with the majority referencing the Enhanced Health in Care Homes programme and specific actions relating to this.

Integrating care - next steps to building strong and effective integrated care systems across England

In early 2021, two key documents were published setting out both NHSE's and the Department of Health and Social Care's proposals with regard to the development of ICSs.

What is clear from these is that the impact of COVID-19 has not dampened expectations around the development of a network of ICSs across England.

In the first of these documents, *Integrating care - next steps to building strong and effective integrated care systems across England*, NHSE set a clear expectation for:

a. stronger partnerships in local places; a more central role for primary care in providing joined-up care
b. formal collaborative arrangements that allow providers to operate at scale
c. the development of strategic commissioning through systems with a focus on population health outcomes
d. the use of digital and data to drive system working, connect providers, improve outcomes and give citizens control of their care.

NHSE also made the case for ICSs to become statutory corporate NHS bodies, absorbing clinical commissioning group functions.[18] This, it is argued, would provide greater long-term clarity in terms of system leadership and accountability through a clearer statutory vehicle.

The document does not, however, make specific reference to the involvement of care providers. Care England has cautioned that, in establishing such arrangements, it is important to recognise that although independent care providers have a relationship with local authorities, they are not represented by them. Future ICS arrangements should therefore include mechanisms to engage and involve the independent care sector in addition to local authorities.

Moreover, whilst recognising the importance and potential of increased use of digital and data, anecdotally, we are aware that many independent care providers are nervous about how this will work in practice. Across ICS', for example, there is the potential for a myriad of data collection systems which could create a significant burden for providers who, often, work across several ICS footprints and would need to respond to each individually. This must be considered both at national and local levels when developing systems and plans.

Integration and innovation: working together to improve health and social care for all

NHSE's report was swiftly followed by a Department of Health and Social Care white paper, *Integration and innovation: working together to improve health and social care for all*, which sets out legislative proposals for a new 2021 Health and Care Bill and further crystalises future ICS arrangements.

As with any white paper, the document presents a partial view of the wider changes that are likely needed to sustain the health and social care sector. Reflecting NHSE's paper before it, the paper is also principally concerned with the NHS, with only limited proposals for social care and public health.

Despite this, there are some important features which it is helpful for us to consider. Firstly, the paper proposes a new legal duty for all NHS providers, together with the new legal entity that is the ICS, to collaborate to address the needs of local populations. This builds on the existing expectation that all NHS providers are in some form of formal 'provider collaborative.' While the detail of such a duty has not yet been provided, it is likely to have positive ramifications for partnership working.

Another key recommendation within the white paper is that the ICS will be led through two different boards, an NHS body and a health and care partnership board, with different roles and responsibilities:

- The ICS NHS body will be responsible for the day to day running of the ICS and be comprised of NHS organisations
- The ICS health and care partnership board will bring together the NHS, social care, public health and other partners from the wider public space to developing a plan that addresses the wider health, public health, and social care needs of the system

ICS NHS board	**ICS health and care partnership**
• Developing a plan to meet the health needs of the population within their defined geography • Developing a capital plan for the NHS providers within their health geography • Securing the provision of health services to meet the needs of the system population	• Developing a plan that addresses the wider health, public health, and social care needs of the system

The proposals in the white paper are for consultation and it is likely that there will be some material changes as it passes into legislation. At the moment, it appears that adult social care and independent care providers can form part of the ICS health and care partnership board. However, as plans are crystalised, further clarity as to whether providers will be directly represented or whether it shall be through local authority social care representatives is necessary. Similarly, it will also be important to clarify how all provider types, such as independent and not-for-profit, can appropriately be represented.

The white paper also makes plain that the ICS NHS board must take heed of the ICS health and care partnership board's plan. However, further detail is needed around what this actually means in practice to convince adult social care and independent care providers that the ICS health and care partnership board is not simply a talking shop.

Making these plans a reality

Earlier this year GGI, in partnership with Care England, hosted a roundtable event to discuss the proposed legislative changes, as well as ICS engagement with the adult social care sector more generally.

From this session and our other research activities, five key themes have emerged that it will be important for NHS and other organisations to reflect on as their ICSs develop:

1. The need for a collective pandemic response has greatly improved relationships and engagement between the health and adult social care sectors.

2. It is at the level of 'place', which is still relatively ill-defined, that adult social care and the independent care sectors can have the most significant influence.

3. There may be significant opportunities to address cross-sector workforce challenges through place-based initiatives and innovations.

4. ICSs have a vital role to play in ensuring the financial sustainability of the adult social care sector.

5. New arrangements have the potential to add complexity to the health and social care sector when simplification is needed. New ICS and place-based arrangements must make sense and add value.

We explore each of these themes in more detail in the rest of this report.

The impact of the COVID-19 pandemic on relationships and behaviours

When gathering insights to inform this paper, those we spoke with broadly agreed that there had been increasing engagement of the independent care sector in system-level planning before the pandemic. This was especially true of those areas that had made progress on the development of provider collaboratives. However, it was also felt that this progress had typically been built around goodwill, relationships and other informal factors rather than any consistent process.

Since the onset of the pandemic, there has been a notable and positive shift in the tenor and tone of relationships. Indeed, we noted in a recent blog that 'there is little appetite within systems leadership anywhere in the NHS to go it alone,' and that 'the challenge from COVID has been so enormous that any patience for parochialism has evaporated.'[19]

At Imperial College Healthcare, for example, the pandemic has provided an opportunity for both the trust and the council to build relationships across the sector, not only with the care homes but also with CCGs, GPs and other local partners. In particular, the trust has been working with local care homes to improve testing capacity, processes including remote monitoring, and training and education so as to help reduce the transmission of COVID-19.[20] We consistently heard in our engagement activities that it was vital that this momentum was not lost.

Recognising this, the people we spoke to felt strongly that now was the right time to reframe how organisations across the health and care spectrum work together in future, with the ICS and place-based arrangements providing the stage for this. It was suggested that this may require a recasting of relationships, as well as a change in the framing of conversations between health and independent care providers, moving from a more commercially orientated discussion to one focused on holistic population health management. Indeed, at our roundtable, the point was made that in order to achieve population health goals, 'ICSs will need to prioritise engagement with local partners, including local authorities and the voluntary sector, and involve patients, communities and, of course, the independent healthcare sector.'

The people we spoke to also articulated a clear need during subsequent recovery phases for ICSs to understand how all areas of the system are performing (including care homes) and for a joined-up approach to addressing system issues. This will require both the establishment of robust and effective governance arrangements and also greater use of data and risk management approaches to ensure that decisions are patient- and client-focused and address recognised needs in primary and social care. Importantly, ICSs must have clarity on the performance and viability of the independent care sector and, where appropriate, this should feature on risk registers and other key risk documentation. The extent to which this is in place is currently variable across the country.

The opportunity of place

Both the Department of Health and Social Care and NHSE's recent papers are relatively vague about place-based arrangements. Within the Department's white paper, for example, there is a section on 'The Primacy of Place' which notes that,

"legislation…needs to be used in a targeted way and in conjunction with a great deal of local and system-level freedom to make arrangements that work for all partners. We will not, for example, be making any legislative provision about arrangements at place level."

However, there is little further detail. It seems likely, then, that it is at the level of place where more flexibility will be afforded for local organisations to determine how best to commission and provide health and care services and, as such, where the independent care sector can best engage.

This was certainly the message that was given at our roundtable event, where one attendee said:

"I'm not certain what an ICS relationship with care providers could offer, because it is about local place-based relationships and local place-based ways of working."

Much of this will depend on how much ICSs embrace the principle of subsidiarity. In many areas we know that independent care providers are already being effectively engaged in nascent integrated care partnerships (ICPs).

However, we were told that there is significant variation in how effectively this is being done across the country. Much of this is dependent on the size of the provider, with smaller providers more likely to be excluded, and the strength of relationships between the various sectors. Certainly, the sheer breadth and diversity of the care sector can make coherent engagement challenging. For example, across Kent and Medway there are more than 750 care home providers of varying size and needs. We also heard that domiciliary services are often overlooked.

To address this issue, we observed several strong examples of independent care providers establishing networks or forming in such a way to allow themselves to engage collectively and effectively with NHS and other public services, with two of these provided below.

South West Care Collaborative

The South West Care Collaborative is a peer-led network supporting care home professionals to deliver high-quality care by sharing best practice across the south west care home community.

It consists of over 900 residential care and nursing homes that work together to:

- review homes rated 'good' and 'outstanding' by the CQC to identify positive elements that can be spread to homes that may require more support
- introduce and test proven innovations through the network
- host training workshops, networking and sharing events to build skills and capacity
- raise the profile of its collaborative and support further potential of the network across the region.

Hertfordshire Care Providers Association

The Hertfordshire Care Providers Association is a membership organisation for adult social care providers in Hertfordshire.

While it offers training and development support, a key part of its role is to act as a collective voice for Hertfordshire care providers when engaging with Hertfordshire County Council, the CQC, CCGs and other public bodies.

We heard in our roundtable that the association was making a material difference in terms of communication and engagement between the health and adult social care organisations in Hertfordshire.

We are also aware that, in some areas, the introduction of a Joint Commissioner is helping with care sector representation and voice.

As mentioned previously, inclusion of local authorities in place-based arrangements will not be sufficient on their own to ensure that the independent care sector voice is heard in decision-making. As such, it is vital that effective mechanisms are introduced to engage appropriately.

Workforce

Since our previous report, the workforce pressures around adult social care services have steadily grown. In 2015/16, we noted that there were around 90,000 vacancies and a staff turnover rate of 27% across the sector.[21]

Today, this has increased significantly to the point that there are now over 122,000 vacancies across the adult social care sector and a turnover rate of 30.8%.[22] It has been estimated that in order to meet increasing demand, between 600,000 and 800,000 additional social care workers will be required by 2035.[23] Indeed, Care England recently co-signed an open letter to the PM calling for a '1948 moment' for adult social care to establish a long-term and sustainable future that will be to the benefit of all citizens and the economy.[24]

In interviews and at our roundtable, it was acknowledged that urgent action is needed to recruit and retain social care staff, with specific attention needed on ensuring staff receive appropriate pay for what are often intensive and highly skilled roles.

At present:

- a quarter of staff are employed on zero hours contracts
- over 20% of care workers are only paid the National Living Wage, with 1 in 5 care workers under the age of 25 paid less
- the proportion of care workers paid on or above the Real Living Wage has decreased significantly from 25% in September 2012 to just over 10% in March 2019[25]

Calls for fair pay for social care staff have only grown louder during the pandemic and
The Health and Social Care Committee has indicated that this must now be an integral part of any long-term funding settlement for social care. In the NHS, proposals for less than generous pay rises for nurses have led to concerns around 'a potential exodus of exhausted NHS nursing staff at the end of the pandemic,' and there can be no doubt that the same is true in the social care sector.[26] Indeed, it has not gone unnoticed that the 2021 Budget was worryingly silent on social care funding.

Likewise, the Department's white paper proposed a new duty for the secretary of state to publish a report every five years setting out roles and responsibilities for workforce planning. However, the NHS and social care still lack a long-term workforce strategy.

Another concern relates to the fact that, despite pressures, NHS staff are comparatively well paid when compared with their social care sector colleagues. Given this, those we spoke to were mindful of the risk that social care staff join NHS organisations in the coming months. Parity in pay between NHS and social care staff would help mitigate this and is something that has been called for by the Health and Social Care Committee, but this is unlikely in the near future. A key challenge is that, whereas in the NHS the majority of staff are employed by the public sector, in the care sector staff are predominantly employed by the private sector. As such, increases in national funding do not always translate into higher wages for staff. This has led to The King's Fund to caution that:

"Proposals for better care worker pay must therefore come hand in hand with ways of delivering it, such as a sector-specific minimum wage or practical ways of requiring better pay when commissioning services. We must also look at how to link training and qualifications to pay and create career pathways across health and care."

In this environment the ICS and place-based initiatives have a vital role to play. Certainly, this was an area where our attendees felt ICSs could make a difference, with representation at ICS level, in some form, seen as key. For example, we heard that:

"There are some quite important system issues for the relationship between the care sector and the ICS and one would be in workforce planning. So, for instance, in thinking about what our nursing needs are going to be going forward, we have also incorporated what the care home sector thinks its needs are going to be."

In 2017, we highlighted how integrated approaches to delivery care might shore up staffing numbers and the same rings true today. This will now include enhanced support from primary care networks (PCNs).

During the pandemic, interim staff passports have also been utilised as a means of enabling safe and rapid staff movement between NHS organisations. This is the first step by NHSE in their ambition to build a strategic digital staff passport, using technology to simplify staff movement between NHS organisations, as outlined in *We are the NHS: People Plan for 2020/21 – action for us all*, and builds upon work already underway such as at the South London Mental Health and Community Partnership.[27] At present digital staff passports are not available in social care organisations. However, in our interviews, it was also suggested that expanding these initiatives to social care could add value and should be explored as one means of addressing workforce challenges.

Many of those we spoke to also highlighted the importance of technology to build capacity within the sector. The Association for Directors of Adult Social Services, for example, has called for steps to reduce duplication across health and social care, including through more collaborative working between patients, care homes and the NHS, supported through assistive technology to facilitate remote care.[28]

Many ICSs will already have, or will be developing, a workforce stream. It is vital that this is appropriately cognisant and reactive to issues within adult social care, and one way of doing this is by ensuring that such groups include adult social care provider representation.

Finance

For many years now, the care sector has been described as 'in crisis' and 'on the brink of collapse,' with a significant number of care providers operating as small family-run businesses, typically on tight margins. Key challenges for the sector include a decline in the fees paid for care by local authorities as a result of the government's austerity programme, as well as a need to fund the recent 6.2% increase in the National Minimum Wage.

In 2017, we noted that close to half of care homes were facing closure at exactly the time when demand was rising. Today, that picture is largely unchanged. For example, a recent study for BBC Radio 4 has suggested that a quarter of care homes were at risk of closure, while a survey by ADASS showed that almost a quarter of directors of adult social services had no confidence that budgets would cover the delivery of statutory duties in 2020/21.[29]

The pandemic has only increased these financial pressures. The Health and Social Care Committee has reported that reduced occupancy rates as well as the increased costs associated with ensuring that care is provided safely (including through appropriate staffing levels, adequate PPE, and the provision of enhanced cleaning) have reduced already thin margins.[30] A recent survey by the National Care Association revealed an average occupancy rate of 81% compared to 92% in August 2019.[31]

The government met an initial £3.2 billion of costs and losses of income incurred by councils in the first three months of the pandemic. However, it has since been estimated that adult social care could need as much as £6 billion more to cover the impact from the rest of the year, and £7 billion per year thereafter to ensure the sustainability of the sector. [32]

Unsurprisingly, Care England and other leading bodies have highlighted that unless additional funds can be made available there is a clear risk to the health of the care sector.[33] Particular risks include that the market retreats to providing care only for self-payers, or that bed capacity/pressure in the NHS increases as a consequence of care home closures.

In all of our engagement activities, one thing that was stressed was the important role that health and social care organisations, including, potentially, ICSs, have as anchor institutions: organisations which have an important presence in a place as a significant employer and purchaser, as well as through their impact on citizen health and wellbeing.

Recognising this, it was felt that ICSs will have a key role to play in supporting the sustainability of the care sector, with effective engagement required to ensure that decision-making adequately reflects local needs.

The potential to delegate commissioning budgets to ICPs was suggested as a mechanism through which the care sector could have a greater say in how services are commissioned to meet the needs of the whole system. Capital or property debt removal schemes were also suggested as means to support the care sector moving forward.

Simplicity rather than complexity

Finally, at our roundtable the point was strongly made that the next round of health and care sector restructuring should aim to simplify the system rather than add complexity. We heard quite clearly that:

> *"The ICS cannot be an additional layer that sits on top of the rest of what is happening."*

And that:

> *"I would say that the system itself is just too complicated. There are too many people trying to take a leadership role in ultimately a place that just needs simplifying."*

Promisingly, in many ways the health and care system is already going through a process of simplification. So, for example, in recent times, we have seen some consolidation of NHS bodies including through CCG and NHS Trust mergers, as well as the introduction of provider collaboratives.

Despite this, the white paper makes a number of proposals that can be interpreted as adding complexity. For instance, it is unclear what the role of the health and wellbeing boards (HWB) will be alongside the new ICS partnership boards. We know that in some areas, ICSs are looking to convert the HWB into the ICS partnership board although this is not commonplace across the country.

For larger care home providers this challenge is exacerbated by the fact that they often work across countries, systems and places, creating different and at times conflicting demands on their services.

Conclusions and next steps

In the four years since we published our report *System transformation and care homes*, much has changed and much has remained the same. On the one hand, we have seen sustained progress towards partnership working both at a system level and a place level, as well as increasing use of technology and innovation to help mitigate many of the challenges that the social care sector faces. On the other hand, workforce pressures have increased significantly and the sector remains precariously placed financially.

In order for progress to be maintained and built upon, we recommend that:

- **The NHS and ICS' engage effectively with adult social care and the independent care sector.** In particular, it is important for NHS colleagues to understand that while local authorities have a relationship with independent care providers, they do not represent them within the ICS. Thought must be given to the most appropriate and effective way to engage with several examples of collective and network engagement provided in this report.

- **We recognise that Covid-19 has forced closer working across systems which needs to be embedded in future working**. It is paramount that a proper relationship between ICS and care providers is established and that this includes involving care providers in decision processes. Ensuring that ICS' are optimised in a way that benefits and includes all stakeholders and doesn't put independent care providers in a sub-position is crucial for these systems to succeed.

- **The shared workforce challenges across health and social care are addressed collectively.** To do this, all ICS workforce groups need adult social care provider representation. As described earlier, this will not be delivered solely through the involvement of local authorities. Having a defined partnership between the health and care sectors will enable a stronger relationship between the sectors.

- **The crucial role that the sector has in local economies and place-based health through employment is acknowledged and supported**. To do this, it is important that care providers are part of the decision process in commissioning budgets. as appropriate.

- **Upcoming legislative changes reduce the complexity within the system to enable care sector organisations to engage as effectively as possible.**

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