Ready to care: the first steps to fixing social care

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Foreword

Social care is a vital sector for the UK economy. It touches the core of who we are as a society: how will we care for the people we love when they cannot care for themselves. It employs 5% of the UK workforce, and caring responsibilities are also the single biggest reason that senior women leave the workforce. Without a functioning social care system, the NHS will always struggle to meet its goals.

The new government has committed to addressing these challenges with a number of important reforms and through unlocking more funding. The recent report from Lord Darzi highlights the imminent need to shift care delivery to the community and hardwire financial flows to enable it. While crucially needed, this will take time and money - and social care in the UK cannot afford to wait.

Social care is a committed, resilient and entrepreneurial sector, accustomed to coming up with solutions and getting things done in spite of limited resources. We therefore want to start a national debate about social care interventions that are quick to implement, low cost and can dramatically change lives.

In this report, we set out seven core recommendations, as developed by interviewing key industry leaders from social care providers, Local Authorities, NHS Trusts, Integrated Care Systems and policy organisations.

We hope that this marks the start of a conversation between the social care sector and the government about how we can work in partnership to improve our system in an environment of constrained public finance.

1. https://www.skillsforcare.org.uk/Workforce-Strategy/resources/Supporting-resources/A-Workforce-Strategy-for-Adult-Social-Care-in-England.pdf

Summary of recommendations

01

Reduce travel times for homecare workers by changing commissioning practices

DHSC should commission an evaluation of neighbourhood models of homecare, aiming to reduce the travel times for care workers that result from framework commissioning. Under neighbourhood models, local authorities would divide their area into neighbourhoods, inviting groups of providers to form consortiums in each neighbourhood to receive all care packages via the framework. Should these models be proven to decrease travel times and increase staff retention rates, they should be rolled out across the country.

02

Allow data-sharing in real time between hospitals and social care providers

DHSC should mandate that social care software providers build open and easily accessible APIs into their products to enable the flow of data from these products to Capacity Tracker. DHSC should also specify data standards to ensure data submitted to Capacity Tracker can be utilised by commissioners regardless of software provider. This would enable providers to continuously and automatically submit comprehensive capacity data to hospitals and commissioners.

03

Seed a Teach First-style programme for social care leaders

DHSC should reallocate £1M of the Workforce Development Fund to establish an employer-led fast-track leadership programme for social care. This would be modelled on the success of Teach First, but applicable to career changers and promising care workers as well as graduates. The initial start-up capital would ensure the programme is self-financing within a year.

04

Streamline the CQC inspection using digital tools

The CQC should reform its assessment methodology, notably around a small number of core quality indicators, tracked digitally from each provider in real time. These would then form the basis of a new, shorter inspection, designed to validate and contextualise this quantitative data.

05

Create a national online support service for unpaid carers

DHSC should commission a national online support service for unpaid carers. This would increase access to high quality information and support for carers, save money for local governments, identify carers who were previously unknown to statutory services and provide a wealth of data to inform policy on unpaid carers.

06

Keep patients out of hospital by delegating healthcare tasks to care workers

Many care workers are already performing a range of healthcare activities guided by national delegation principles. NHS England should encourage the widespread expansion of this practice by developing delegation frameworks for three key acute conditions (UTI, pneumonia, cellulitis) and three key chronic conditions (diabetes, dementia, hypertension) responsible for unnecessary emergency admissions, which would expand community care capacity and keep thousands of patients out of hospital.

07

Boost integration between the NHS and social care

DHSC should prioritise integration between the NHS and social care by introducing secondary legislation to the 2022 Health and Care Act, requiring integrated care boards (ICBs) to include the Director of Adult Social Care from a partner local authority.

Introduction

Adult social care faces significant challenges.

Large numbers of elderly and disabled people cannot access the care they need, with more than 400,000 awaiting assessment.[2] Those in this situation often end up being admitted to hospital or left in hospital, unable to be discharged. This stems from two distinct economic models driving older adults to end up in the hospital when they should be taken care of at home, as highlighted in Lord Darzi's investigation.

Care outcomes are inconsistent, with many recipients not having the independence and quality of life they deserve. In the long term, the financial sustainability of the entire health and care sector is in doubt, with an ageing population suffering from a variety of chronic conditions.

The new government has committed to addressing these challenges.[3] It is proposing new Employment Rights legislation which will enable unions representing care workers to negotiate with providers on a Fair Pay Agreement, aimed at reducing workforce shortages and increasing capacity. It will create a National Care Service to ensure consistent quality and outcomes across the country, and it will move healthcare into communities, promoting integration between health and social care and preventing illness before it happens. The Darzi report supports these initiatives.

These reforms are important and necessary, but will take time and money when the sector desperately needs help **now**.

In this report, we set out seven pragmatic, high-impact, low-cost recommendations that can be implemented before the end of the year. These are the first steps towards achieving the government's goals of increasing social care capacity and facilitating discharges in the short term, improving care outcomes in the medium term and ensuring the financial sustainability of the sector in the long term.

We have developed these recommendations by interviewing the leaders of key stakeholders: social care providers, Local Authorities, NHS Trusts, Integrated Care Systems and policy organisations. Where possible, we have linked these to four case studies of impressive practice from across the country.

Despite the challenges, a core theme throughout all of our interviews was of a passionate, innovative, deeply committed social care sector that is ready to step up and work with the government to reform social care and improve the lives of millions across our country.

2. https://www.adass.org.uk/adass-snap-survey-21-rapidly-deteriorating-picture-of-social-care-services/

3. https://labour.org.uk/change/

Increasing social care capacity and facilitating discharges

There is insufficient social care capacity in the UK to meet the country's needs; in March 2024 there were 418,029 people on local authority waiting lists, with 78,641 waiting longer than six months.[4]

This is an untenable problem: hundreds of thousands of elderly and disabled people are going without the support they need, undermining their independence and worsening their health.

However, the lack of capacity in social care also has a significant impact on the NHS. Following treatment in hospital, many patients require ongoing care and support in order to be discharged. Social care plays a crucial role in supporting the NHS by enabling this, ensuring the timely discharge of patients, and ultimately freeing up hospital capacity.

However, there are often significant delays in arranging social care packages for patients, estimated to cost the NHS 1.1 million bed days a year.[5] The most important cause of these delays is the lack of capacity in social care, with three quarters of medically fit patients in hospital in winter 2022/23 awaiting the availability of social care, and 64% in April 2024.[6]

The biggest limit on social care capacity is the sector-wide recruitment and retention problem. The vacancy rate for care worker positions is 8.1%, almost three times the UK average, and the yearly turnover of care workers is 25.6% (data from July 2024).[7] Although these figures have improved since the pandemic due to international recruitment, they are still too high, and levels of international recruitment have decreased by 80% this year.

Social care providers struggle to recruit and retain workers for a variety of reasons. Some care workers have little training and career progression; zero hours contracts are common, meaning care workers do not have guaranteed income. However, the biggest problem is pay. The median hourly rate for care workers in December 2023 was £11.00 – only 58p higher than the National Living Wage and less than offered by competing industries like retail and hospitality.

For homecare workers (43% of the social care workforce), long travel times between clients push overall pay significantly lower, as local authorities only pay for a few minutes' travel time per visit. Indeed, the Homecare Association estimates that homecare workers spend almost a fifth of their working day travelling between people's homes.[8]

4. https://www.adass.org.uk/wp-content/uploads/2024/07/ADASS-Spring-Survey-2024-FINAL-1.pdf
5. https://www.countycouncilsnetwork.org.uk/new-report-sets-out-how-hospital-admissions-can-be-avoided-and-how-patient-flow-can-be-improved-ahead-of-busy-winter-period/finding-a-way-home-ccn-newton-3/
6. https://www.countycouncilsnetwork.org.uk/new-report-sets-out-how-hospital-admissions-can-be-avoided-and-how-patient-flow-can-be-improved-ahead-of-busy-winter-period/finding-a-way-home-ccn-newton-3/
7. https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/Topics/Monthly-tracking/Recruitment-and-retention.aspx
8. https://www.homecareassociation.org.uk/resource/homecare-association-publishes-minimum-price-for-homecare-2024-25.html

Long travel times for homecare workers are created by the method of commissioning used by local authorities. In the UK, the majority of care is commissioned via a framework agreement with local providers. Here, on a case-by-case basis, packages of care are tendered to a list of registered providers, often numbering in the hundreds.

Some framework contracts have predefined terms, conditions and prices - others will only award contracts to the lowest rate bidder. When a package of care is tendered via the framework, many registered providers will bid for this package – driven by the necessity to generate revenue and the reality that, if they don't take the package, their competitor will.

This creates a situation where each local provider has clients arbitrarily dotted over an area - often with multiple providers serving the same street - leading to significant, unnecessary travel times for care workers.

We therefore recommend that DHSC commissions an evaluation of neighbourhood models of homecare, aiming to reduce the travel times resulting from framework commissioning.

Under these new models, local authorities would divide their area into neighbourhoods and invite groups of providers to form consortiums in each neighbourhood that receive all care packages via the framework.

Each neighbourhood would contain around 200 care recipients, and be geographically defined based on natural communities, public transport routes and the distribution of care needs.

Within each neighbourhood, consortiums of providers would work together and use their current rostering software to optimise travel times. Local authorities could select consortiums based on quality metrics and employment practices – ensuring that providers of all sizes are represented.

If the evaluation of these new models shows a decrease in travel times and increase in staff retention rates, they should be rolled out across the country.

Indeed, as documented in the case study below, a similar approach piloted by Leeds City Council halved the turnover of care workers. These models also have a number of benefits for care recipients, including greater continuity of care workers and more opportunities for care workers to take on healthcare tasks.

Current commissioning practices are often highly prescriptive, with tasks performed at specific times for specific patients. For non-time sensitive tasks, this leaves little choice for care recipients to decide what time is most suitable for them and little scope for providers to optimise their rounds. We would therefore encourage that the evaluation also considers how commissioning models could grant providers more flexibility in delivering care.

Recommendation 01

Reduce travel times for homecare workers by changing commissioning practices

DHSC should commission an evaluation of neighbourhood models of homecare, aiming to reduce the travel times for care workers that result from framework commissioning. Under neighbourhood models, local authorities would divide their area into neighbourhoods, inviting groups of providers to form consortiums in each neighbourhood to receive all care packages via the framework. Should these models be proven to decrease travel times and increase staff retention rates, they should be rolled out across the country.

Another significant barrier to discharging patients from hospital is poor coordination between discharge teams and care providers.

Hospitals find it difficult to identify social care providers with capacity for the care required, slowly exchanging emails and calls with a multitude of providers for each patient discharged. Providers often find discharge documents not reflective of patients' needs and views, or that care needs differ from the package paid for.

Even if providers have capacity, it is often of the wrong type. Local commissioners lack the data needed to match capacity in different levels of care to demand, meaning the shortfall in home-based care is around 2.5 times greater than the shortfall in residential/nursing care, and 4 times greater than the shortfall in rehabilitative care delivered in a bedded setting.[9]

It is important to remember that this has serious implications for patients: if an elderly individual receives more intense care than is necessary, this leads to reduced independence, deconditioning and, ultimately, worse long-term outcomes.

In theory, hospitals and commissioners have access to a web-based tool - Capacity Tracker - commissioned by NHS England and DHSC, which enables them to view the capacity of local care providers. However, as providers are only mandated to input data to Capacity Tracker on a monthly basis, hospitals do not have real-time information on which providers have capacity. Manually entering data is also very time consuming for providers, and a lack of data standards governing the data submitted to Capacity Tracker means that datasets are often incomplete and not useful to commissioners.

The majority of social care providers are now using rostering software that tracks their capacity in real time. In light of this, we recommend that DHSC mandates social care software providers to build open and accessible APIs (Application Programming Interfaces) into their products toto enable the flow of data from these products to Capacity Tracker. We also recommend DHSC to specify data standards in order to ensure data submitted to Capacity Tracker can be utilised by commissioners regardless of software provider.

In the short term, this would facilitate discharges by allowing hospitals to quickly identify which social care providers have availability, therefore optimising the use of the limited capacity already in the system. More importantly, the high-quality data collected would allow managers and commissioners to conduct evidence-based capacity and demand planning. In practice, this would mean identifying the type of care for which there is the biggest shortfall in capacity relative to demand (likely home-based care) and targeting resources to these areas, thereby facilitating discharges and ensuring the best use of resources.

In the case study discussed below, Leeds Health and Care Partnership developed a system visibility tool to share data between local partners, leading to an 11% increase in patients discharged to home-based care and a 30% reduction in hospital bed days lost due to delayed discharges.

9. https://www.countycouncilsnetwork.org.uk/new-report-sets-out-how-hospital-admissions-can-be-avoided-and-how-patient-flow-can-be-improved-ahead-of-busy-winter-period/finding-a-way-home-ccn-newton-3/

Recommendation 02

Allow data-sharing in real time between hospitals and social care providers

DHSC should mandate that social care software providers build open and easily accessible APIs into their products to enable the flow of data from these products to Capacity Tracker. DHSC should also specify data standards to ensure data submitted to Capacity Tracker can be utilised by commissioners regardless of software provider. This would enable providers to continuously and automatically submit comprehensive capacity data to hospitals and commissioners

Attracting and retaining staff in social care starts with leadership, and social care offers great opportunities for people to build their careers. Leadership roles in social care are well-paid (a Registered Manager earns between £35-60k), have a clear sense of purpose and a great deal of autonomy. The work is engaging and ever-changing. And yet, social care has a critical leadership problem.

There are three current gaps to address:

- The lack of appropriate available training to enable people to become registered managers
- The lack of career framework for ambitious people who wish to enter the sector in a leadership role
- The lack of knowledge of and excitement for career opportunities available in social care: while the NHS is seen as a highly desirable employer, social care is seldom a route that high-achieving graduates are attracted to

Consultation has shown that there is strong support from care providers to develop a care leadership programme to attract talent into care leadership. Modelled on the success of Teach First, Frontline and Police Now, in 2022 the Care Tech Foundation published a business case for such a programme. This work was funded by leading care providers, with a proposal to establish a charitable organisation similar to Teach First to run and deliver the programme, jointly funded by government and care providers.

While such a scheme would be hugely advantageous to the sector, the cost of delivering the programme as designed may prove unpalatable in the current fiscal environment. We therefore propose that the current proposals be adapted in four ways:

1. Such a programme should not be limited to young graduates, instead it should be opened up to career changers and current social care staff who wish to develop their careers, particularly those with previous career histories in regulated health care fields overseas.

2. The programme would develop its own leadership curriculum. This would be recognised by the CQC as a qualification appropriate for registered manager status, and would be distinct from the current NVQ Level 5. This would provide critical skills and knowledge related to care delivery and management, and would also include skills such as commercial awareness, financial planning, process mapping and improvement, data analysis, and technology development. This is not covered in existing industry qualifications.

3. The government should provide a small start-up grant of £1 million to develop the new curriculum and support structure. After this point, the programme should be entirely self-financing, something that can be achieved by providers employing programme participants and covering their salaries, and participants contributing a proportion of their salary to cover the

training cost. The start-up grant could come from current Workforce Funding and therefore not add any additional cost to the exchequer.

4. Rather than establishing a new organisation, the programme would be overseen by Skills for Care, who would run a procurement process to choose a delivery partner. This partner should be chosen by employers and officials.

In addition to addressing the problems set out above, the programme would help to retain highly skilled overseas care workers (e.g. former doctors and allied health professionals) in the care sector at the end of their five-year visa period. Many currently see the NHS as the only source of progression.

Recommendation 03

Seed a Teach First-style programme for social care leaders

DHSC should reallocate £1M of the Workforce Development Fund to establish an employer-led fast-track leadership programme for social care. This would be modelled on the success of Teach First, but applicable to career changers and promising care workers as well as graduates. The initial start-up capital would ensure the programme is self-financing within a year.

Improving care outcomes

High-quality social care forms the bedrock of our society, enabling millions of elderly and disabled people to live the lives they want to live. The majority of social care delivered in England meets this standard, with 64.4% of recipients very satisfied with their care and 69.7% feeling safe.[10] However, there is also significant variation in quality, with one in four providers delivering substandard care.[11] This can be unsafe, undignified, and rob people of their independence.

As the regulator of social care services in England, the CQC bears ultimate responsibility for maintaining safe, high-quality care for recipients. At its best, the CQC is a key partner, working with providers to help them improve their services. However, in recent years, the CQC has failed to deliver on this purpose.

This has resulted in the government commissioning an independent review into the operational effectiveness of the CQC, with an interim report published in July this year. Our interview findings echo many of the conclusions found within the report, as did a recent report published by the Homecare Association:[12]

- There is a lack of clarity in how the CQC reaches its ratings, meaning providers do not have defined goals to work towards.
- Providers are often left for long periods without inspection (the oldest rating for a social care organisation is nine years old), meaning ratings are not a true reflection of current quality of care, and bad practice goes unnoticed.
- New providers wait many months for CQC registration, with 54% of applications more than 10 weeks old, creating an unnecessary barrier to entry for a market in need of support and capacity.

We therefore recommend that the CQC reforms its assessment methodology, notably around a small number of core quality indicators, tracked digitally from each provider in real time.

These would then form the basis of a new, shorter inspection designed to validate and contextualise this quantitative data. By putting defined quality indicators at the heart of assessment, the CQC would set a clear goal for social care providers, who could then work to raise the quality of their care. Providers could continuously self-evaluate with 'mock digital inspections', not having to wait for inspection reports.

These changes would also allow the CQC to shorten their inspection times – which currently can take days – as the purpose would only be to ensure that the data is a fair reflection of the provider in question. In turn, this would increase the capacity of the CQC, enabling them to inspect providers more often and increase the speed of registration of new providers. Furthermore, by monitoring the core quality indicators in real time, the CQC would be able to prioritise inspecting those organisations at risk of delivering poor quality care.

Digital tools are the crucial enabler here. Today, most care providers have care planning or care management software to run their operations, allowing them to routinely collect and hold large amounts of care data. Some even include analytics to allow care providers to leverage this

10. https://files.digital.nhs.uk/40/1896D4/meas-from-the-asc-of-eng-2022-23-report_v2.pdf

11. https://www.homecareassociation.org.uk/resource/homecare-association-report-exposes-serious-deficiencies-in-homecare-regulation.html

12. https://www.homecareassociation.org.uk/resource/homecare-association-report-exposes-serious-deficiencies-in-homecare-regulation.html

data for quality improvement, such as Birdie's Q-Score, which is modelled after the CQC's own criteria.

Over the last ten years, the CQC has spent more than £130m on IT systems, including for care inspections, data collection and analysis. It therefore has the infrastructure for leveraging digital data extracted from care planning systems to inform inspections.

It would therefore be simple for core quality indicators to be generated from providers' software and automatically sent through APIs to the CQC in real time. Indeed, NHS England could mandate social care software providers to build these APIs as part of the Digital Social Care Records framework.

Reflecting all of this, our recommendation aligns with the direction of travel of the CQC, which aims to develop a streamlined approach to assessment with data collected in advance as part of an 'always on' insight system.[13]

Recommendation 04

Streamline the CQC inspection using digital tools

The CQC should reform its assessment methodology, notably around a small number of core quality indicators, tracked digitally from each provider in real time. These would then form the basis of a new, shorter inspection, designed to validate and contextualise this quantitative data.

Improvements to the quality of care must also discuss the more than five million unpaid carers in the UK, who provide vital support to friends and family, enabling them to remain independent for as long as possible. Unpaid carers are the backbone of the social care system, and the value of this care is estimated to be £162 billion – just shy of the entire NHS budget.[15]

However, many struggle to balance work and care: according to one estimate by Carers UK, 600 people leave the workforce per day to care.[16] Furthermore, the day-to-day stresses of caring can have a deleterious effect on health and wellbeing: NEF Consulting estimates there are 107,000 carer breakdowns each year resulting in the need for state intervention, 10% of which result in admissions to residential care.[17] This exerts more pressure on the social care system, harms government finances, and impacts our economy.

Digital tools can improve access to information and support carers at a lower cost. One meta-analysis highlighted that digital tools can be a 'cost-effective and convenient' way to 'help unpaid caregivers form communities, gain support, and access resources'.[18] This can help carers build resilience which helps to avoid, delay or reduce the need for crisis interventions.

Existing digital platforms have also shown an ability to engage significant numbers of carers who are unknown to statutory services, a critical ability when only 8% of carers are identified by relevant services.[19] Furthermore, the data collected by digital tools can provide a wealth of insights to inform policy, including on issues carers face at a national and local level.

13. https://www.gov.uk/government/publications/review-into-the-operational-effectiveness-of-the-care-quality-commission/review-into-the-operational-effectiveness-of-the-care-quality-commission-interim-report#appendix-5---previous-assessment-model
14. https://www.carersuk.org/policy-and-research/key-facts-and-figures/
15. https://www.bbc.co.uk/news/uk-england-south-yorkshire-65459014
16. https://www.carersuk.org/policy-and-research/our-areas-of-policy-work/juggling-work-and-unpaid-care/
17. https://nefconsulting.com/wp-content/uploads/2019/06/Unpaid-Carers-Technical-Note-Accompanying-Model.pdf
18. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7837-3
19. https://www.health.org.uk/publications/long-reads/understanding-unpaid-carers-and-their-access-to-support

We therefore recommend that DHSC commissions a national online support service for unpaid carers. This would increase access to quality information and support for carers, save money for local governments, identify carers who were previously unknown to statutory services and provide data to inform policy on unpaid carers.

The national online support service would build on and supplement existing initiatives offered by local government, charities and private companies (as shown in the case study below). A consortium of local governments could co-fund the platform - which we estimate would cost £10 million a year - giving each a stake in its success. To incentivise continuous improvement to services, the service contract could have contestability clauses linked to measured outcomes, with the option to change vendors if these metrics are missed.

Recommendation 05

Create a national online support service for unpaid carers

DHSC should commission a national online support service for unpaid carers. This would increase access to high quality information and support for carers, save money for local governments, identify carers who were previously unknown to statutory services and provide a wealth of data to inform policy on unpaid carers.

Ensuring the financial sustainability of health and care

The UK has an ageing population. This is exerting significant pressure on the NHS, with two out of every three hospital beds and half of all ambulances arriving at A&E occupied by a patient over the age of 65.[20]

As the population continues to age, these pressures will only get worse. However, health and care spending in real terms is at its highest-ever level (£190bn in 2023/24), and there is little room to increase this amid stagnating growth and significant challenges facing other public services.[21]

Lord Darzi argues that "care should be delivered in the community, closer to where people live and work, and that hospitals should be reserved for specialist care. This is more convenient for patients – especially for those with long-term conditions who will need contact with the NHS more frequently.[22] The only way to make health and care financially sustainable is to shift resources into the community, preventing illness and costly hospital admissions in the first place. The future of care will rely on local communities caring for older adults spanning from health and care professionals to unpaid carers - a 'village of care'.[23]

The starting point for preventative healthcare is the reducing of the number of emergency admissions of elderly patients. Age UK estimates that better community care for elderly patients could have prevented 855,000 of the 6.5 million emergency admissions across the entire NHS in England in 2019/20.[24] These admissions either resulted from acute conditions that should not require hospitalisation with the appropriate care in the community (e.g. UTIs, pneumonia, cellulitis), or exacerbations of chronic conditions which have been suboptimally managed in the community (e.g. diabetes, dementia, hypertension). Similarly, the Darzi report refers to research from the NHS Confederation finding that, on average, systems that invested more in community care saw 15 per cent lower nonelective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and A&E attendances.[25]

In turn, the cause of this poor community care is simply a lack of capacity, particularly amongst GPs and district nurses. An estimated 1.6 million elderly people have unmet needs for care and support.[26] In surveys of elderly people, 45% were concerned about their ability to access their GP and 40% did not feel they had enough support to manage their health conditions.[27]

The government has indicated that it will ask regulators to investigate the role care workers can

20. https://www.bgs.org.uk/policy-and-media/protecting-the-rights-of-older-people-to-health-and-social-care#:~:text=The%20current%20health%20and%20social,health%20and%20social%20care%20services.

https://www.ageuk.org.uk/latest-press/articles/2023/the-crisis-in-the-nhs-is-largely-a-crisis-in-older-peoples-preventive-care-and-if-were-to-avoid-another-catastrophic-winter-in-nine-months-time-we-need-to-act-now-to-fix-it-warns-age-uk/

21. https://ifs.org.uk/data-items/uk-health-spending-real-terms-and-share-gdp-1949-50-2022-23

22. https://assets.publishing.service.gov.uk/media/66e1b49e3b0c9e88544a0049/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England.pdf

23. https://www.birdie.care/village

24. https://www.ageuk.org.uk/latest-press/articles/2023/age-uk-issues-clarion-call-for-a-big-shift-towards-joined-up-home-and-community-based-health-and-social-care-services-for-older-people/#:~:text=The%20rate%20of%20 A%26E%20attendances,care%20at%20the%20right%20time.

25. https://assets.publishing.service.gov.uk/media/66e1b49e3b0c9e88544a0049/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England.pdf

26. ibid

27. ibid

play in basic health treatment and monitoring, as part of its effort to move healthcare into the community. The reality is that this is already happening in many areas of the country – as shown in the Leeds City Council case study later in this paper – using national delegation principles set out by DHSC and Skills for Care. Here, a regulated clinician asks a care worker to perform a given healthcare task, ensuring that the care worker has the appropriate skills to do this and remaining accountable for the care given. Often, care workers and clinicians visit patients at the same time, meaning clinicians can teach care workers how to perform certain tasks and subsequently delegate them.

An important example of widespread delegation is the Delegation of Insulin Administration Program, which was developed by Diabetes UK, the NHS and other national stakeholders. This sets out a systematic mechanism for care workers to take delegated responsibility for administering insulin. When piloted across 22 adults with diabetes in residential and care homes, it saved 5,425 hours of district nurse time across the course of a year and reduced the incidence of acute diabetes complications.[28]

We therefore recommend that NHS England develops similar frameworks for three acute conditions (UTI, pneumonia, cellulitis) and three chronic conditions (diabetes, dementia, hypertension) that often lead to unnecessary hospital admission, and encourages their widespread use.

For each condition, these frameworks would define which healthcare tasks and which patients are suitable to be delegated to care workers, and the steps needed to do this in practice. This would enable care workers to optimise the chronic conditions of those under their care, whilst also helping GPs and district nurses manage acute conditions like pneumonia - which traditionally would have led to hospital admission - in the community.

As care recipients represent a significant proportion of those in hospital, this practice would prevent thousands of unnecessary admissions. It would also drive workforce retention in social care, as care workers would learn skills that enable them to pursue a long-term career in healthcare, representing a first step towards the government's goal of formally upskilling care workers.

Funding and technology will be crucial to this recommendation's success. Care providers need to be compensated for taking on healthcare tasks, and systems can flexibly use a variety of local funding streams to take advantage of this newfound, cost-effective community capacity.

Some Primary Care Networks (PCNs) are already subcontracting home visits to care providers, but in the case study below Leeds Community Healthcare NHS Trust funds delegated tasks carried out as part of a homecare contract tendered by Leeds City Council.
Technology can support care workers to take on healthcare tasks in a variety of ways. For example, we anticipate the delegation frameworks for acute conditions being used in virtual wards, with care workers documenting observations and administering treatments whilst overseen digitally by a clinical team. Currently, most care workers use mobile apps to record their care visits, medication management and observations. In the future, assisted by technology like AI, they could become healthcare assistants for chronic conditions, delivering personalised and preventative care.

28. https://diabetesonthenet.com/journal-diabetes-nursing/a-collaborative-approach-to-insulin-delegation-a-pilot-to-drive-system-change/

Recommendation 06

Keep patients out of hospital by delegating healthcare tasks to care workers

Many care workers are already performing a range of healthcare activities guided by national delegation principles. NHS England should encourage the widespread expansion of this practice by developing delegation frameworks for three key acute conditions (UTI, pneumonia, cellulitis) and three key chronic conditions (diabetes, dementia, hypertension) responsible for unnecessary emergency admissions, which would expand community care capacity and keep thousands of patients out of hospital.

The most important enabler of the previous recommendation – and, indeed, of all preventative work carried out within systems – is integration. Integrated Care Systems (ICSs), NHS Trusts, PCNs, local authorities and social care providers need to work together to plan and commission health and social care to keep people out of hospital, avoiding a narrow focus on short term outputs.

For delegating healthcare tasks to care workers, this means deciding how to optimally use this capacity and how to pay for it, and then connecting clinicians and care workers to allow training and oversight. Integration between health and social care is also necessary to address other inefficiencies within systems, most notably delayed discharges.

The 2022 Health and Care Act created the statutory conditions for integration in the form of ICSs. ICSs are composed of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs). ICBs are responsible for commissioning services to meet local health needs. ICPs convene key stakeholders, including the NHS, social care providers and local authorities to develop an integrated care strategy that ICBs must take into account when making decisions.

However, despite this statutory framework, in many areas NHS organisations and social care providers still operate largely independently. This is because ICBs are stretched, financially constrained and accountable to NHS England – therefore find it difficult to prioritise social care.

In addition to this, there are rarely senior figures within ICBs with clear responsibility to drive integration between health and social care. ICB boards – which hold ultimate responsibility for commissioning decisions – are largely made up of NHS representatives and often have only one or two local authority partner members responsible for bringing the full range of local authority concerns to the table (of which social care is only one example).

Although ICPs include social care representatives, these bodies do not hold decision making power, and integrated care strategies are often overlooked in the face of acute NHS pressures. So although providers and local authorities want to work with the NHS on social care, they do not have a clear route to doing so.

We therefore recommend that DHSC introduces secondary legislation to the 2022 Health and Care Act that requires ICB boards to include the Director of Adult Social Care from a partner local authority or any equivalent representation.

This would prioritise social care for integration with the NHS, given its immediate importance to preventing admissions and facilitating discharges. The new board member would have a clear mandate to foster joint planning between health and care, in addition to promoting much-needed communication between the two sectors. This builds on best practice across the country, with some ICBs like Norfolk and Waveney already having a Director of Adult Social Care on their board.

Recommendation 07

Boost integration between the NHS and social care

DHSC should prioritise integration between the NHS and social care by introducing secondary legislation to the 2022 Health and Care Act, requiring integrated care boards (ICBs) to include the Director of Adult Social Care from a partner local authority.

Case studies

In this final section, we present four case studies of innovative practice happening right now across the UK.

These exemplify many of the points made in this report, and show that - despite the significant challenges facing social care - there are numerous examples of providers and local authorities addressing capacity constraints, facilitating discharges, improving care outcomes, working preventatively and integrating with the NHS.

Neighbourhood models of homecare: Leeds City Council

Similar to the rest of the UK, in 2020 homecare capacity in Leeds was insufficient to meet local demand.

The main cause of this was a significant workforce shortage: providers struggled to recruit as they couldn't compete with retail and hospitality on pay, and the turnover of care workers was 36%.

To address this challenge, Leeds City Council developed an innovative commissioning model in collaboration with Leeds Community Healthcare NHS Trust, which is currently being piloted.

This model divides Leeds into natural neighbourhoods, and two care providers (BeCaring and Springfield Homecare) are building teams in each neighbourhood responsible for 95% of the care packages arising via the framework. Within each area, these teams are able to optimise and reduce travel times.

The council has funded a trusted assessor function in the service model to ensure care packages are the right size for each recipient, leading to a more efficient use of hours, and enabling care workers to be paid their full shift rather than on a case by case basis.

As well as increasing the recruitment and retention of care workers, this approach increases continuity of carers for recipients, and gives care workers the flexibility to deliver more person centred care. Any downtime during shifts must be used for the benefit of the care recipient, including undertaking delegated healthcare tasks - such as medication prompts or emptying catheter bags, with an ambition to extend to insulin administration and wound care - paid for by Leeds Community Healthcare NHS Trust.

A smaller-scale pilot of this model in 2020-22 was evaluated by Leeds Beckett University as significantly reducing the turnover of care workers and improving the satisfaction of care recipients.

Supporting unpaid carers: Mobilise

Mobilise is a B Corporation that provides an online support service for unpaid carers in 30 local authorities across the UK.

It uses digital marketing to identify large numbers of carers who do not realise they are carers, and then connects them together in an

online, supportive community. Mobilise also provides a range of information and advice, such as a course detailing the foundations of caring for new carers, signposting to local resources, and eligibility checkers for benefits like carers allowance. Carers in particular need of support are also able to arrange free calls with coaches or fellow carers.

Based on outcomes in Local Authorities currently commissioning this service, Mobilise's internal modelling suggests that if the platform were rolled out across the country it would reach 2 million unpaid carers a year, 80% of whom would have never received support in their caring role before. It would save local systems a minimum of £120 million per year by decreasing the demand for formal care services and improving the outcomes of care recipients, whilst also reducing numbers of carers leaving the workforce by 10%, boosting the economy by £130 million per year.

Sharing data: Leeds Health and Care Partnership

Leeds Health and Care Partnership is formed of health and care organisations across Leeds, and is part of the wider West Yorkshire ICS. It is currently implementing a HomeFirst programme that aims to increase the numbers of patients discharged into their homes supported by domiciliary and community care services.

This is underpinned by a 'system visibility tool', which is a live dashboard accessible to all system partners displaying real-time capacity data from hospitals, social care providers, rehabilitation services and neighbourhood teams. The data can be viewed in different ways, from overarching system trends, to the capacity of specific health and care providers, and even individual wards and patients.

Managers are using this tool to make better decisions about the flow of patients through hospitals and to social care providers, and commissioners are optimising the use of resources and capacity across the whole system. Since the roll out of this tool, there has been an 11% increase in patients discharged to home-based care and a 30% reduction in hospital bed days lost due to delayed discharges.

The power of integration: Birmingham and Solihull ICS

In 2012, hospitals in Birmingham had a significant problem with delayed discharges. The local NHS realised that a lack of integration between different health and social care providers was an important cause of this.

On average, within 24 hours of discharge, a patient would receive five different assessments: e.g. discharge nurse, community nurse, homecare provider. Many patients were waiting unnecessarily in hospital for all of these services to become available at once.

To address this, local commissioners formed a partnership between health and social care. They engaged a large social care provider - Sevacare - to run a single discharge visit and share the assessment across all parties.
A key innovation was placing the NHS budget in the hands of Birmingham City Council, immediately establishing trust between the two bodies.

Following a series of pilots, a full contract was agreed in 2019 and is ongoing. An independent evaluation shows that, in the last 12 months alone, this service has prevented over 272 000 bed days lost to delayed discharges and saved the NHS over £147 million.

Signatories

Martin Jones MBE - CEO, Home Instead

Camille Leavold - CEO, Abbots Care

Darren Stapelberg - CEO, Grosvenor Health & Social Care

Lucy Campbell - CEO, Right at Home

James Townsend - CEO, Mobilise

Sam Hussain - CEO, Log my Care

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