Introduction to the Adult Social Care Sector

English Community Care Association Seminar
Objectives

• To provide an introduction to the independent social care sector and the variety of services and care provided

• To aid Clinical Commissioning Groups commissioning social and health care services from this sector and demonstrate the sector’s potential to help them meet local and national health priorities including better integration and QIPP

• To share best practice examples of joint commissioning and integrated care services working to deliver and improve high quality care

• To share examples that aid compliance with the Royal College of General Practitioners Competency Framework and Commissioning Curriculum
## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CHC</td>
<td>Continuing Heathcare funding</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>ECCA</td>
<td>English Community Care Association</td>
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<td>EMI</td>
<td>Elderly Mentally III</td>
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<td>EOLC</td>
<td>End of Life Care</td>
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<td>HoNOS-LD</td>
<td>Health of the Nation Outcome Scale for people with Learning Disabilities</td>
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<td>NICE</td>
<td>National Institute of Health and Clinical Excellence</td>
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<td>RCGP</td>
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Introduction

The Department of Health defines social care as:

“the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships.”

The independent social care sector consists of both charitable and commercial care providers. In 2009, there were approximately 17,300 organisations in England providing or organising social care for adults.

The majority of these providers operate within the independent sector. 73% of care homes are privately-owned, 19% are owned by charities, and just 8% are run by councils.
Introduction

Since the passing of the 1990 NHS and Community Care Act, local authorities were encouraged to become purchasers rather than providers of services. Councils have found it increasingly cost-effective to stop their in-house provision in favour of outsourcing.

The majority of local authority provision is therefore outsourced; approximately 90% of their residential care support and 81% of home care hours are delivered by independent sector providers. Around 80% of learning disability support services are contracted out by local authorities.3

Social care services are usually needed because of old age, learning or physical disability, long-term conditions or mental illness. The independent sector provides a wide range of services and types of care, including:
Introduction

- Residential Care Homes
- Nursing Care Homes
- Domiciliary care
- Supported Living
- Extra Care Housing
- Sheltered Accommodation
- Respite care
- Intermediate care
- Rapid Response care
- Practical help, e.g. shopping assistance
- Personal Assistants

The sector also has a wealth of knowledge and experience in areas such as:
- Neurological rehabilitation
- Elderly Mentally Ill care
- Palliative and End of Life Care
- Dementia care
Personalisation

Social care providers aim to deliver a person centred service that reflects the social care policy focus on personalisation. The promotion of greater choice and control for individuals is fundamental to good quality care.

Think Local Act Personal (TLAP) is a sector-wide commitment to moving forward with personalisation and community-based support. The overall aim is to secure a shift to a position where as many people as possible are enabled to stay healthy and actively involved in their communities for longer. Those needing more targeted services, including end of life care, should have maximum control over this.

Integration between health and social care, delivery of personal budgets and closer working with independent providers, are key elements of ensuring real progress on delivering a personalised care and support service.

See www.thinklocalactpersonal.org.uk
Case Study 1: Reablement

Working in partnership with Hampshire County Council, Barchester Healthcare is providing reablement beds across four care homes. This work started in December 2010 during a period of increasing pressure on the acute NHS system and a need for a care pathway for older people needing rehabilitative support before returning home.

These beds have been successful in helping individuals who require a longer period of recovery following a stay in an acute hospital. Patients qualify for the support if:

• a long-term decision is not certain – for example in instances where there is an opportunity for better recovery and improvement to the individual’s independence
• the individual (and possibly family members) has lost confidence in the individual’s ability to return home safely
• a full review of all of the options available to the individual have not been explored due to the need for early discharge from hospital.

8 weeks after Barchester were approached by Hampshire County Council, the service was up and running. Once an individual is in a reablement bed, the care home works with local adult social services, multi-disciplinary teams and the individuals and their families to plan for longer term care needs.
Sector Statistics

The current demand for social care:
• By the end of 2010, there were over 200,000 people aged 65+ in residential care funded by the council or NHS. A further 120,000 people in care homes are self-funded.
• 650,000 people received state funding for non-residential social care services. It is difficult to estimate the number of self-payers receiving non-residential care, but it is probably around 200,000.⁴

The growing demand for social care:
• It is predicted that by 2026, an additional 1.7 million adults in England will have care and support needs.⁵
• The number of people with dementia in the UK will increase from 750,000 to over 1 million people by 2025.⁶
• The number of people with a learning disability needing care or support will increase by 50% by 2018.⁷
Sector Statistics

Increasing numbers of people with multiple conditions are requiring social care:

• For example, the number of disabled older people is expected to rise by 108% to 4.95 million by 2041.8

• The Department of Health estimates that 15 million people (1 in 3 of the population) have a long-term condition. Whilst this will probably remain consistent, the number of people with comorbidities is predicted to rise by a third in the next 10 years.9

Social care sector growth:

• Between 2007 and 2010, the number of registered care homes did decrease slightly. However, CQC recorded an increase in domiciliary care providers (+965), day care services (+6,900) and registered community services (+3,900).10

The social care sector will play a key role along with healthcare services in meeting the demands of demographic change and the personalisation agenda.
Sector Regulation

The Care Quality Commission (CQC)
• The independent regulator of health and social care in England. Providers undergo risk-based inspections and are regularly measured against compliance with 16 essential standards of quality and safety. CQC is redeveloping it’s compliance assessment methodology.
• In May 2010, the CQC announced that they were replacing their ‘star’ quality rating system with a new ratings scheme. Until this new quality rating system is finalised, services will keep their old rating.11

Local Authorities
• The majority of councils and PCTs conduct contract monitoring. However, some have also established separate quality assurance schemes.

Monitor
• We understand will have a role in social care in the future but the details of this are still to be agreed.

• National Institute of Health and Clinical Excellence (NICE)
• Will develop quality standards for social care as part of the NHS reforms and plans to better integrate health and social care.
Commissioning Quality

There have been incremental improvements in the standard of care over the past eight years. Between 2008 and 2010, the proportion of services in the independent sector rated ‘good’ and ‘excellent’ rose by 15%.\textsuperscript{12}

Commissioners are a crucial driver for improved quality, and consortia must work to ensure care services continue to raise their standards of care. The RCGP Competency Framework for Commissioning emphasises how this can be done in a number of ways, including:\textsuperscript{13}

\begin{itemize}
\item Shaping the market of willing providers (4.6)
\item Commissioning services on the basis of quality and value for money, rather than cost (4.5; 5.3)
\item Rewarding quality through procurement and contracts (4.5; 5.2)
\item Investing in training for sector (5.2)
\item Sharing information and expertise (5.2)
\item Establishing partnerships in commissioning and provision (3.3)
\end{itemize}
http://www.cqc.org.uk/_db/_documents/Adult_social_care_market_BRIEFING.pdf

CQC, Market profile, quality of provision and commissioning of adult social care services, November 2010

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annag, 18/02/2011
Sector Funding

Access to social care is means-tested, and the independent sector is financed through a complex system of various funding streams:

- Self-funders
- Local authorities (central government grants to councils and council tax revenues)
- Personal Budget holders
- Service user or family contributions to local authority care packages (top-ups)
- NHS funding (Continuing Healthcare and Funded Nursing Care)
- Disability-related benefits (Including Attendance Allowance, Disability Living Allowance, Severe Disability Premium in Pension Credit)

Commissioners can currently purchase care through block or one-off ‘spot’ contracts.

In 2009-10, around £16 billion of public funds were spent on social care. Another £5.5bn was spent by self-payers and people ‘topping-up’ council care home fees.\textsuperscript{14}
Despite accurate demographic predictions about the ageing population since the late 1980s, the social care sector has seen a consistent lack of strategic funding. To meet the needs of an ageing population, more investment in both training and infrastructure for the sector is needed.

- Public spending on social care will double in real terms by 2025/6 - an increase of 3.2% per annum - as the population ages and unit costs of care increase.\(^{15}\)

- The King’s Fund has estimated that there could be a state funding shortfall of £6 billion by 2026 even if current need is met and funding is increased by 2% in real terms.\(^{16}\)

Numbers of those receiving NHS continuing healthcare funding varies.

- For example, Wiltshire and Essex have similar population demographics, with around 20% of their population aged 65+. At the end of 2010, Wiltshire PCT had awarded CHC funding to approximately 50 people per 50,000 of their county population. In contrast, the Essex PCTs averaged just 30 per 50,000.\(^{17}\)

The following slide illustrates the growing financial pressures of the growing demand for social care:
Financial Pressures on Social Care, England, 2007 prices
Julien Forder (2010) Reforming social care funding: Presentation to King’s Fund Board Leadership Programme 10 June 2010; PSSRU
An increase in future funds for social care was announced in the October Comprehensive Spending Review. This included:

- Local government to receive an increase in social care funding of \textbf{\£875 million a year} (on average over the next four years) the formula grant (not ring-fenced)
- A further \textbf{\£1 billion} allocated to social care spending from the NHS Resource budget
- \£150 million in 2010-2011 from this NHS \£1 billion has been earmarked for re-ablement or post-discharge services such as occupational and physiotherapy, home adaptations or domiciliary care. This will increase by \£300 million per year for the rest of Parliament.

However, although the \£1 billion for local government bodies is labelled as additional funding, it should be viewed in context of an reduction of \£6 billion in the overall formula grant by 2014-15.

- It is estimated this reduction to the formula grant will result in significant cuts to social care spending and a funding gap of \£1 billion could still emerge by 2014.\textsuperscript{18}
Sector Funding

Increasing spending on social care provision can generate significant efficiency savings elsewhere in NHS budgets:

• Better care in the community can prevent unnecessary readmissions and save £2bn annually. Such support is particularly significant for patients aged 85+ as this age group has seen emergency admissions increase by 48% since 2005.

• A study conducted by the Nuffield Trust in 2010 focused on over 16,000 people in 3 PCT and council areas. They found higher social care costs at the end of life were associated with lower inpatient costs, and reductions in council-funded social care may increase demand for acute care.

Andrew Lansley has promised there will be a “line of accountability” to ensure money earmarked for preventative care will both “deliver improvements in health gain as well as social care support”.

• This emphasis on preventative care provides a key opportunity to improve the interaction and partnerships between health and social care commissioners and providers
Case Study 2: Telehealth

Working in partnership with NHS Norfolk, telehealth services in Barchester Healthcare’s Woodside care home has successfully reduced the number of hospital admissions by 16% for the Thorpewood GP practice in Norfolk.

Telehealth is characterised by use of computer systems which allow health professionals to monitor residents’ health remotely. The project is used as an ‘early warning system’, with the key objective being quicker medical intervention and reduced hospital admissions.

This was achieved in Norfolk with the ‘Care Closer to Home’ project, which involves use of a dedicated bed managed by the local GP practice. Beds are devoted to short-term rehabilitative goals over an admission period of no more than five days.

Telehealth supports an approach with outcome-focused care goals that empower patients to maximise self-management. It dramatically reduces the need for hospital admissions and markedly improves quality of patient experience and choice by providing localised and easy access services.
Partnership Working

Partnership working between health and social care professionals and organisations has been a recurring aim of public policy for the past 40 years. It was recently emphasised in the latest NHS reforms as being “essential for patient outcomes”.22

Integrated care delivery may involve partnerships, pooled budgets (joint financing) and integrated systems as well as organisations that cross typical boundaries between primary, community, secondary and social care.23

Integrated projects can lead to substantial efficiency savings and quality improvements:
• Early intervention programmes run by a partnership of health and social care providers can generate savings of between £1.20 and £2.65 for every £1 spent24
• Integrated delivery encourages better communication and decision-making pathways, improves coherency, flexibility and seamlessness of service delivery
• The following diagram further illustrates the interrelation between health and social care for patients

Currently, just 3.4% of the combined, national health and social care budgets are spent on joint-financing and commissioning.
Partnership Working

Figure 13: Overlap of people using health care and social care services in a typical locality

Number of people aged over 55 registered continuously with local GPs, 2005-2008: 77,000

People receiving secondary care: 53,000 (69% of registered population)

People receiving social care: 13,000 (17% of registered population)

90% overlap

Source: Nuffield Trust.

Partnership Working

The independent care sector can assist GPs in meeting their outcomes and targets for delivering good quality care. The RCGP’s Competency Framework for Commissioning states:25

3.3 Partnering with providers
Effective commissioning takes place within a culture of shared values and collaborative working between commissioners and providers.

Services are best designed using a multidisciplinary partnership of clinicians and managers from primary, secondary, tertiary, community and third sector providers.

Consortium leaders should build relationships with providers built on trust, mutual respect and two-way communication, putting the needs of patients and the public first, and supporting providers in delivering the best possible care.

Although there are many challenges, such as separate budgets and statutory responsibilities, that can hinder partnership arrangements, there is great potential for Clinical Commissioning Groups to save money, improve quality of care and receive support through working with the independent care sector.
English Community Care Association

The English Community Care Association (ECCA) is a registered charity and the leading representative body for community care in England. ECCA members provide a wide range of care and support services; residential and nursing settings, domiciliary care and housing support for adults, including those with physical and learning disabilities.

Our members represent the diversity of the independent sector and include charitable and commercial, large and small providers.

ECCA campaigns to ensure the optimum environment exists for independent care providers to give high quality care for those who wish and need it.

For more information or to contact independent sector care providers in your area, please email ann.mackay@ecca.org.uk.
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5. CQC (2009) *The state of health and adult social care in England: Key themes and quality of services in 2009*


7. Learning Disability Coalition (2011) *Stories from the Frontline*


9. Department of Health  


11. Under the old CQC quality rating system, providers were assessed and awarded a star rating. These were: 0* = poor, 1* = adequate, 2* = good and 3* = excellent

12. CQC (2010) *Market profile, quality of provision and commissioning of adult social care services*

13. Royal College of General Practitioners (2011) *Commissioning Competency Framework*  
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25 Turning Point Centre of Excellence in Connected Care, Benefits realization: assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care