Sustainability, Innovation and Empowerment: A Five Year Vision for the Independent Social Care Sector
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Foreword

Increasing demand and diminishing resources have made integration between health and social care a necessity, and mean that the next five years will be absolutely crucial in ensuring that the care and support services that many rely on remain sustainable.

This positive vision for the future attempts to define the contribution that the independent care sector can make in order to ensure that joined up services become a reality, but also attempts to outline the way in which the health service must adapt to provide care in a new way.

Positive changes have happened over the course of the last five years. From the publication of the NHS Five Year Forward View to the establishment of the Better Care Fund, system leaders have realised that the existing ways of doing things are no longer suitable in terms of dealing with the problems that we currently face.

We feel that enough positive initiatives are in place for us to seek evolutionary rather than revolutionary changes. That is why we will support Monitor’s reform of the payment system, CQC’s plan to increase the number of integrated inspections and the implementation of the Five Year Forward View.

We will also initiate change by ending the payment of retainer fees to GP practices, establishing a new advanced care practitioner role to ease the nursing shortage crisis in care homes, and creating the framework for a sector-wide staff survey to be established in order to boost workforce engagement.

That is not to say that we will not be pushing national and local organisations to improve outcomes for the people that we care for however. Amongst other things, CQC must be given oversight of commissioning to ensure that commissioners are laying the groundwork for the provision of good care; the NHS must do more to open up access to training programmes; and system leaders must do more to confront the nurse recruitment crisis facing both health and social care.

This document therefore outlines a work programme that we as an organisation, and as a sector, will take forward, but also notes the contributions that will be needed from other colleagues in order to ensure that continuous improvement can be achieved – even in a period of diminishing or modest resource growth.

Professor Martin Green OBE, Chief Executive of Care England
Key things that we will deliver

• The introduction of a new nursing role sitting between a care worker and a nurse in order to ease the recruitment crisis in care home nursing

• The establishment of a sector-wide staff survey across the care home sector – similar to that which exists in the NHS

• We will continue to provide additional capacity for the NHS at critical times such as Winter

• We will continue to be involved and promote Care Home Open Day as a means of demonstrating the important role that care homes play in communities

• We will continue the pioneering progress that our sector has made in caring for people with long-term conditions such as dementia
Key contributions needed to enable progress

- Care home nurses to be added to the Shortage Occupations List to enable providers to recruit from outside the European Economic Area. Body responsible: The Migration Advisory Committee.

- Local authorities to pay care homes fees that reflect the cost of providing services and paying staff the Living Wage. Bodies responsible: The Department for Communities and Local Government, The Treasury, local authorities.

- The nursing curriculum has to be broadened out in order to give trainees more exposure to the care sector, and the opportunities it offers. Body responsible: Health Education England.

- Politicians need to start talking up the sector rather than using rhetoric to encourage the existing pernicious stereotypes that many people hold. People responsible: The Secretaries of State for Health and Communities and Local Government, The Care Minister, The Prime Minister.

- The Care Quality Commission must be given oversight of local authority commissioning to stop poor practice, such as commissioning on price and not quality, and late fee payments. Bodies responsible: The Department of Health, The Department for Communities and Local Government, The Department for Business, Innovation and Skills.

- Unnecessary duplication of regulation must be cut out in order to free up providers’ time to provide care to service users. Bodies responsible: Local authorities, CCGs, CQC, The Department for Business, Innovation and Skills.

- Some providers noted that the communication from government on reforms is not always clear and have asked that every effort is made to ensure that policy is clearly communicated in future.
Integration (Care centred around the individual)

We as a sector fully support integrated care as a means of achieving better outcomes for people, providers and commissioners. Where different components of the health and social care interface have come together with the express purpose of improving outcomes, the results have been extremely impressive.

In Salford for example, some of the initiatives put into practice include having a GP practice that exists solely to care for residential and nursing home residents, and a forum in which GPs and psychiatrists discuss complex individual cases of people living in care homes. Such an approach enables outcomes to be improved and money to be saved – as it is a well-known fact that the most costly intervention from both a financial and quality of life perspective, is an emergency admission to hospital.

For this reason, we support the outcome focused Better Care Fund, and are cautiously optimistic about the potential of the decision to allow Greater Manchester to have autonomy over its £6 billion health and social care budget.

However, integration must be a means to an end and not an end in itself.

Without set outcomes, the pooling of budgets has the potential to exacerbate the status quo in which politicians and the media focus on aspects of physical health – which are nonetheless important – at the expense of areas that are perceived to be less important to the public.

This trend was replicated within the NHS itself over the course of the last Parliament, where despite the fact that mental and physical health are largely commissioned from the same budget, data from 34 mental health trusts obtained by the BBC and Community Care, revealed that community mental health budgets were cut by 4.9%.

People cared for in the independent care sector have often worked their entire life or have been born with disabilities that are no fault of their own. They do not deserve the prospect of seeing a diminution in their funding due to a perception that the public care more about the NHS than they do about social care.
Over the next Parliament, we hope to see take-up of personal budgets increase amongst those receiving care in the independent care sector, and for direct payments to be rolled out across the residential care sector. To facilitate this, providers will continue to ensure that unless there is a statutory or insurmountable obstacle, the choice of the service-user to access services from elsewhere will always be respected.

We also support the establishment of new models of care. As medical technology has improved, life expectancy has correspondingly increased. The Health and Social Care Information Centre reported last year that between 1980 and 1982, men were expected to live a further 13 years after retirement, and women a further 17 years. However, that figure has now increased to 18 years for men and 21 for women.

Whilst this is something to be celebrated, it also calls into question the suitability of the current operating model.

The NHS’s own projections state that long term conditions account for 70% of total hospital and primary care budgets, which to a large extent can be accounted for by the fact that longer life expectancies also signify a greater amount of time spent in ill-health.

The Office for National Statistics note that at the age of 65, men have a healthy life expectancy of 10 years, with the corresponding figure for women being recorded as 11.5 years. This means that in the modern day, a considerable proportion of a person’s later life is likely to be spent in ill-health.

For this reason, it makes very little sense to have dividing lines separating primary care, hospitals and social care, when people with long-term conditions – working age or elderly – frequently use all three. Instead, care for these people must become far more holistic with different elements of the system working together rather than in isolation.
The care home can be the perfect place for these barriers to be broken down, and the benefits of doing so can be seen in both of these examples:

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

(Taken from the NHS Five Year Forward View)

The aim of this project is to enhance the quality of care for care home residents by improving the coordination and management of each resident’s care needs. In 2012, five community nurse practitioners (CNPs) were assigned to individual South Worcestershire care homes to deliver the project via the production of clinical management plan (CMP) for each home resident…

At the end of March 2014 the project resulted in the production of CMPs for 2,100 care home residents in South Worcestershire. In year one, evaluation of this project revealed a 26.5% reduction in all admissions when compared to the same period in the previous year, with a 23.1% reduction in A&E attendances from care homes, with savings in the region of £700,000.

(Taken from Integrated Care Pioneers: One Year On NHS England)
That is why we hope to see initiatives such as the enhanced healthcare in care homes model outlined in the Five Year Forward View become commonplace across the country, as an evidence base exists to demonstrate that improved access to GPs amongst care home residents significantly improves their chances of not slipping into crisis.

It is also the reason why we support new commissioning models such as integrated care organisations in which a single commissioner arranges the totality of the care of a population group and is given the pooled budget in order to do this.

Intelligent initiatives such as these have the effect of enabling a certain amount of stability in the maintenance of current structures, whilst at the same time ensuring that funding streams and incentives are aligned to make sure that these structures do not operate in silos.

The eradication of these silos will in turn break down monopolies that organisations have due to lack of competition. The NHS is right to recognise that without an incentive for its component organisations to radically redefine their offer, the £22billion target of efficiency savings will be unrealisable.

New contracting models can incentivise quality to be maintained, and integration at scale is the only way in which such a large amount of savings can be located. Without both of these being present, the NHS will fail to meet the target that it has set itself. In other words, integration is no longer a nice-to-have; it is now a must-have.

**Key offer:** We will work with the NHS in order to reduce emergency admissions from care homes that could be prevented through more co-ordinated care, and support the new care models around enhanced healthcare in care homes.

**Key ask:** We hope to see good local practice be promoted from the centre to a greater extent.
Fees and co-operation

We accept the pressure that local authorities have been under over the last five years. Faced with a 40% cut in central government grants and limited capacity to increase council tax, local government has had to cut expenditure. Despite making an attempt to shield social care from the cuts, with adult social care spend as a proportion of local government budgets increasing from 30 to 35% over the last Parliament, the budget was still cut by 16% in total.

Providers have attempted to help local authorities over the past few years — making efficiency savings in order to accept below inflationary fee rises and fee freezes where possible. However, we have now reached the point at which if the status quo remains, the sustainability of the independent care sector will be called into question. With council run homes already deemed unviable by many local authorities, the prospect of diminishing supply would leave a huge gap in the provision of care for a number of individuals with high needs.

In other words, this really is a crisis, and one that providers and commissioners must work together to solve.

The mechanisms are now in place in order for stakeholders to work together to agree fees and sufficient levels of support to meet an individual’s care needs. Commissioning for Better Outcomes for instance enables local authorities to assess each other’s commissioning levels against a set of metrics to determine whether outcomes are being commissioned; the Provider Protocol – a joint venture between the LGA and provider sector, sets out a code of conduct for how commissioners and providers should approach each other when interacting; and co-operation is now even on the statute book in the form of the section on Integration, Co-operation and Partnerships in the Care Act.

Increasing instances of Judicial Review and continued provider attrition are the only consequences culminating from the current ways of working. Neither commissioners nor providers can afford the former, and the individuals that we care for cannot afford the latter. The last paragraph shows that the frameworks are in place in order for improved co-operation to happen, and there is no longer any justification for the poor engagement, which we have witnessed in certain parts of the country.
Over the next five years, we therefore propose that commissioners and providers work together in agreeing the sufficiency of an individual’s care package, rather than this being set as part of an arbitrary standard rate. In order to facilitate this process, providers should be able to demonstrate to local authorities that they are innovating to the degree necessary to offer commissioners a diverse care market, whilst commissioners must display confidence in CQC by removing the duplicative regulatory processes that they undertake, which are a source of unnecessary bureaucracy.

However, for this shared working to happen, funding is nevertheless needed. The major driver of ill feeling between providers and commissioners is fees. If local authority budgets continue to be cut as the Government has pledged, then councils will not be in a position to offer fair rates to providers, and as a consequence, it is unlikely that the shared working that both us and LAs would like to see happen will take place.

It is absolutely essential therefore that central government acts to head off the crisis in residential care by ring-fencing the funding that councils receive to commission these services to enable quality to be maintained. In return, local authorities must commission care at representative rates and engage with providers in a fair manner.

**Key offer:** We will continue to innovate and diversify the market from which commissioners purchase care through investment in developments such as dementia specialist units.

**Key ask:** Local authorities have to pay for this innovation through paying providers fees that reflect the cost and sustainability of the service provided.
Nursing

Following the publication of Sir Robert Francis’s report into patient safety in Mid-Staffordshire NHS Foundation Trust, the Government decided to place additional focus on safety and quality, which it would deliver through a more rigorous inspection regime led by CQC.

This focus, which we agree with, has had profound implications across health and social care, but one of the main impacts has been in relation to nursing where acute trusts have made the decision to increase nursing numbers. This has impacted upon the independent care sector in two ways.

Firstly, due to generally better terms and conditions in the NHS, it has always been the case that the health service has been able to recruit nurses directly from the independent sector and has had a vastly superior success rate in terms of recruiting nurses available to both sectors. This trend has been exacerbated due to increased recruitment on the part of the NHS.

Secondly, when both the NHS and independent care sector cannot recruit nurses on a permanent basis, they use agency staff to make up their numbers. With both sectors stretched, there is now a situation in which competition for this pool of temporary staff has been enhanced.

A survey of Care England members carried out in November 2014 revealed that most vacancies in the care sector go unfilled for at least 6 months, with some being empty for around 2 years. It is clear that this situation is not sustainable, and Care England will over the course of the next Parliament attempt to take concrete steps to ensure that a solution is found.

Migration:

One of the primary means of filling nursing vacancies when nurses cannot be easily sourced within the UK is to recruit from abroad. Freedom of movement within the EU facilitates this to an extent, but many of our member organisations have reported that due to nursing shortages across the continent, even recruiting from the EU is becoming difficult.

This only leaves the possibility of recruiting nurses from outside the European Economic Area, but the migration target set by the last government and continued by the current administration substantially limits the ability of organisations to do this, without receiving special dispensation.
That special dispensation comes from the Migration Advisory Committee, who through the Shortage Occupations List can specify different professions in which the need for workers is so great, that organisations are allowed to recruit them from outside the European Union.

We attempted to get care home nurses on the List when a review was undertaken last year, but along with health were unsuccessful in doing so. Care England will therefore present an evidence base to the new Home Secretary outlining the urgent need for nurses from our sector to be added to the List. To assist in making this case, we have appointed two honorary nursing advisors. We also hosted a joint conference with the Royal College of Nursing at the end of May, and will look to work closely with them on areas of shared interest in the future.

A new hybrid role:

We have been working to lay out the ground for a new hybrid role in the independent care sector, which would fall between a care worker and a nurse. Such a position would enable registered nurses to take on more of a supervisory role, whilst these assistant care practitioners – as they would be known – carry out the practical elements of nursing care. These practical duties may include for instance continence assessments and sore prevention assessments and planning.

In order to qualify to carry out this role, prospective assistant care practitioners would undertake supervised learning modules, which would be internally verified through supervised practice. Standardisation would be achieved through a requirement to undertake courses at accredited universities, which would also require workers taking on this role to be enrolled on a voluntary register. For the role to have legitimacy, CQC approval would be essential, and we are confident of working with the regulator to achieve this by the time it is introduced.

In 2014, Skills for Care estimated that the cost of recruiting a new member of staff is around £3000 in total once training, advertising and all other costs are taken into account. Although this figure is large, it is likely that the cost of recruiting a care home nurse is far higher due to the length of time that vacancies are left unfilled, high nursing staff turnover – estimated at 32% by Skills for Care – and the cost of advertising in a multitude of different places.
We therefore see this new role representing a significant cost saving to the independent care sector – not only through allowing the prospect of services having to hire less nurses, but also by way of the impact it will have on the current nursing stock, who will be able to take on more of a leadership role. Career progression is an important factor in encouraging retention, and if nurses feel that they are able to use their expertise to lead rather than merely administer nursing care within homes, it is probable that they will be more encouraged to stay at these services.

Although we expect to achieve results in these areas, it is still essential for central government to recognise the importance of care home nurses in both the training that the NHS provides, and the rhetoric that national politicians deliver.

At present, the nursing curriculum is heavily geared towards the acute sector. To many trainee nurses, a career in hospital is the only realistic option presented to them, and we believe that given the importance of nursing, and number of nurses in our sector, this is completely wrong. Instead, when nurses carry out placements, they should experience care home nursing, and the different challenges and opportunities that a career in this sector presents. Such a change would be a firm signal from the centre that the recruitment issues in nursing are facing all parts of the health and social care system, and not just the NHS.

**Key ask:** Care home nurses to be added to be Migration Advisory Committee’s Shortage Occupations List.

**Key offer:** We will develop a new role within the care sector to contribute towards easing the nurse recruitment crisis.
Workforce

The adult social care workforce encompasses approximately 1.5 million workers, which means that it employs more people than the NHS. Skills for Care estimate that with increasing demand stemming from higher life expectancies across the population, pressure on social care services will continue to grow and as a consequence, 1 million new jobs will be needed across the sector.

In addition, the same organisation projected that staff turnover in terms of registered nurses in adult social care settings is around 32%. However, the role with the second highest turnover in the sector is that of the care worker, where there is a turnover rate of around 27%. Combined with high vacancy rates, it is clear that the adult social care sector has a problem in terms of both recruiting and retaining staff.

Whilst health care obtains its name from the nature of the service provided, social care derives its label from the way in which care is provided. So much of what goes on in our sector is built upon relationships between care staff and the people they care for. Relationships can often only be built over time, and that is why we see turnover and the causes of it as being such a huge issue. Turnover is also such a problem when one considers the demand related pressures and need for new workers outlined by SfC.

Below are two of the main variables that determine both recruitment and retention. Many providers do not have it in their gift to unilaterally make a positive impact in either area, which is why we have outlined some initiatives involving an array of different bodies, which if put into place, we believe could help to address this issue.

Pay:

The competence and wellbeing of those who work in the independent care sector is of vital importance, and we fully support the steps that CQC have taken to ensure that this is reflected in their inspection methodology. However, whilst regulation can enable wellbeing to an extent through ensuring that organisations are well-led, it cannot contribute to the financial wellbeing of those who work in the sector.
Commissioners, providers and regulators alike are all in agreement that when one considers the complexity of their duties and the challenging situations that they often face, care workers are not paid a salary that befits the enormous contribution that they make. This is especially the case in services with a high degree of state funded residents, and a consequent low degree of cross-subsidy. Providers of these services cannot afford to sustainably pay staff at rates that they would otherwise like to, and this is a problem that we all must confront.

The fact that providers are in a position where current fee levels make the Living Wage unaffordable can be seen in research carried out by the independent Low Pay Commission. In The Commission's annual report in 2014, they noted that along with childcare, labour costs in social care are higher than in any other low-paying sector, and on average, amount to 61% of a provider’s turnover.

Similarly, the bite of the National Minimum Wage (its ratio to median pay in a sector) is rapidly increasing in adult social care relative to the rest of the economy. In 2007, the bite in our sector was 66%, but by the time the Commission published its report in March 2015, this figure had risen to 80%. This is in comparison to the rest of the economy in which the bite is only 46.2%, a small increase from the 41.2% recorded in 2001.

When one considers the amount of turnover that independent care providers are spending on staffing, one can see the huge challenge that we as a sector face in paying the Living Wage. Indeed even in relation to the impending increase in the National Minimum Wage, the Commission cautioned that social care might struggle to bear the increased cost, noting:

*We also remain concerned about the pressures the increase will place on social care. We urge the Government to ensure funding is available to meet the extra burden the NMW rise will place on the sector.*

Nevertheless, we do remain committed to becoming a Living Wage sector. The social justice argument is one that we and our members have always advocated but with wage growth beginning to pick up again as a result of a recovering economy and demand increasing year on year, it could be argued that moving towards the Living Wage has now become a necessity.
The Resolution Foundation costed such a policy at just over £2 billion. We believe that this is a reasonable amount for government to pay in the sense that it amounts to only a year’s worth of the increases that the NHS has been promised in this Parliament. In addition to this, a YouGov poll commissioned by the Care and Support Alliance, revealed that increasing funding for social care was the electorate’s second biggest priority behind spending more on the health service.

In the Office for National Statistics' analysis of household expenditure for 2013, they demonstrate that the lowest ten per cent of earners spend a higher proportion of their income than higher earners, and most of this money is spent locally. Whereas higher earners spend proportionally more on activities outside of their resident communities such as restaurants and hotels, the total expenditure generated by low income earners is more geared towards the communities in which they live. For instance, housing and power costs contribute towards 25% of this group’s overall spend, whilst transport and education come in at 9.8 and 2.2% respectively.

Consequently, through providing low income earners with more resource, it is likely that they will spend the money on activities and services that stimulate local economies, which benefits other areas of local authority budgets. This further offsets the costs that it would take to introduce this policy.

Funding the transition would therefore achieve many different aims. It would raise the value of the sector, demonstrate that the Government takes social care as seriously as it does the NHS, raise the quality of life of a number of workers, and perhaps most importantly in a political sense, would enjoy broad political support.

We believe that this should be a priority over the coming Parliament. 

**Training:**

As well as being paid sufficiently, staff also need to have access to continuing development and career progression to deal with the problem of high staff turnover. We hope that the new nursing role mentioned in the previous section will offer a career path for talented members of the workforce, but we also acknowledge that more has to be done in terms of opening up access to training opportunities.
In an era of integration, all sides need to bring expertise and experience to the table and deploy it across the system. Whilst independent care practitioners are placed well to offer preventative care to large groups of people with long-term conditions, thus alleviating pressure on the health service; the health service can contribute to both improving and enabling this care through offering courses and ongoing training to staff in the independent care sector.

Such a move might make a dent in the high staff turnover rate that currently blights the independent care sector. This is crucial as continuity of care is of paramount importance to those managing long-term conditions, and if a small gesture such as enabling a staff member to enrol on an NHS training course helps to contribute to that continuity, then the policy would be in keeping with the NHS’s central mission to improve physical and emotional wellbeing.

In terms of specific training programmes, these would obviously have to be different depending on the role that an individual carries out within the care sector.

For managers, who often have to co-ordinate care with and across a range of different services, we would encourage the extension of the Edward Jenner Programme to registered managers in the care sector. The fact that the programme is free, online, and can be completed at a manager’s own pace would make the programme feasible – in a cost sense for the NHS, and in a time sense, as it would not place restrictive burdens on the manager’s time.

Many healthcare assistants are also supported to work towards vocational qualifications such as NVQs, and support to do the same for care workers who spend a significant amount of time caring for NHS funded residents and homecare recipients, would go a long way towards boosting retention.

In return, we believe that the independent care sector can offer the NHS reciprocal hands-on training in relation to dementia and other long-term conditions in which our sector specialises. Sharing knowledge is absolutely vital in integrated care environment, and both sides must do more to make this standard practice.

**Key offer:** As a sector, we will continue to pay a far higher proportion of turnover in labour costs relative to other industries.

**Key ask:** We are supported to pay the Living Wage and offered shared training opportunities with the NHS in order to reduce staff turnover and attract new employees.
The Value of the Sector

A lot of what underpins the problems that affect particularly residential and nursing homes, are the perceptions that people have in relation to these types of services. Although many people feel negatively towards hospitals, they are still regarded as places where an improvement in your condition/life is possible, and are consequently seen as being essential.

This is not true when it comes to care homes, which are primarily seen as places where an individual goes towards their end of their life once they have begun to deteriorate, and continue to do so until they die. People are understandably terrified about the possibility of this happening to them and therefore refuse to engage with or challenge this negative stereotype.

Their refusal to do so means that they are not able to appreciate the range of different residential settings on offer for individuals with varying degrees of need. In addition, they do not hear about the extraordinary examples of compassionate care delivered across the sector on a daily basis.

An example of the excellent care provided in residential settings can be seen in the video at the following link:

http://www.careengland.org.uk/orchard-care-homes

Significantly, also, when politicians make pledges on funding during election campaigns, the care sector is often nowhere to be seen, as the public are not mobilised to campaign on its behalf. This is a sector that is also rarely thanked by our national leaders for its contribution and the difference it makes, unlike NHS staff who often receive such praise.

Challenging this cultural stereotype is something that we have attempted to do repeatedly over a long period of time. We will continue to challenge negative and ignorant representations of the sector when we see them through making care homes more accessible where possible.

Accessibility is absolutely key in driving change. Care homes are a vital part of communities and where possible, should be places in which people of all ages and backgrounds can come together. However, people do not realise the opportunities for bringing people together that care homes offer and we intend to continue promoting these.
We have had great success in helping to lead National Care Home Open Day over the last few years, which has seen prominent figures – such as George Osborne – spend a day or a few hours at a care home. We will continue to expand this initiative over the next five years.

Additionally, we recognise that a lot of people now receive their information through social media. This makes it imperative for providers to be adept at using tools such as Twitter and Facebook to promote a positive image of their service and sector. We are offering training in social media over the next few months, and will continue to organise similar ventures over the coming years.

It is important for those with an expert knowledge of the independent care sector to be able to use their vote to support the sector. We will therefore campaign over the course of this Parliament to increase the numbers of residents and members of care staff on the electoral roll.

We are hopeful that the increased exposure that integration gives people to a range of different services is a key mechanism in changing opinions that they might hold. Above all, we are mindful of the fact that it will take longer than the course of a Parliament to alter views that have held for decades, but we are hopeful that in five years time, we will be further along the path of having achieved this goal.

We need to see national and local politicians speak up for this sector.

Key offer: We will continue to make care homes more accessible through initiatives such as National Care Home Open Day, and through offering training opportunities for organisation to better engage with social media.

Key ask: National and local leaders need to do far more to present a positive image of the sector and lead by example through visiting more services.
Care Quality Commission

We have been impressed by the distance that CQC has travelled in developing its methodology. Throughout the course of the development process, providers, commissioners and service-users have been involved, and although not perfect, the end product has been much improved as a consequence.

Rather than responding to the poor care uncovered at Mid-Staffordshire, Winterbourne View, Morecambe Bay and other settings through tougher regulation for regulation’s sake, we have moved from a system of measuring compliance to a regulatory regime that measures performance across five key domains.

However, there are still areas in which CQC need to improve, and as a consequence of the new models of care being established across the country, the regulatory model will have to adapt regardless.

One of the biggest issues our members have in relation to regulation is duplication. Regulation is necessary to provide assurance to both potential and current service-users and their families, but there is no excuse for different organisations asking for the same information on multiple occasions.

Members often complain about how they produce information for CQC, only to be told weeks later that the local authority requires them to go through the work of producing this evidence once again. This takes already stretched staff away from the frontline to produce information that would be unnecessary to produce if there was better co-ordination between the regulator and commissioner. Last year, in a report on the administrative burdens faced in care homes, the Joseph Rowntree Foundation projected that as much as 20% of a manager’s time can be taken up by paperwork. We hope that as the new methodology beds in, local authority trust in CQC will enable them to ease the regulatory burden on providers.

Similarly in relation to CQC’s own work, we feel that there are a number of areas in which the regulator could permit independent care providers to have more liberty. For instance, in Northern Ireland, nurses are allowed to administer intravenous drips, which is a function that care home nurses in England could easily carry out. CQC’s core function is enabling the delivery of high quality care, and allowing staff to carry out functions that they are capable of performing is vital in achieving this.
We are also concerned that for 2015/6, the fees that independent care providers pay CQC have risen by 9%. This worries us for two reasons. Firstly, adult social care has a higher cost recovery than any other sector, yet this is not reflected in the push towards overall cost recovery, with a 9% rate of increase being universal across the board.

In addition to this, as David Behan noted at CQC’s Board meeting on 21 January, CQC has not yet hired the number of inspectors necessary to carry out its new methodology. He set the organisation a target of recruiting 300 inspectors by April 2015, which has been achieved, and a further 300 by the end of the year. For the financial year 2015/6, CQC’s business plan projects that staffing costs will be £179 million, amounting to 71% of the overall budget.

That figure of £179 million does not take into account the fact that the next tranche of inspectors will not be in place for the entirety of the financial year, meaning that staff costs are guaranteed to be higher in 2016/7. This will inevitably result in higher provider fees, placing added strain on already stretched provider finances. Care England feels that with ever-increasing fees, there could come a point at which the cost of regulation is a factor in determining whether a business decides to either enter or even remain in the market.

Whilst we agree with the aim of full cost recovery in the long-run, we think that a balanced approach needs to be taken in moving providers towards this goal, which reflects how much progress different sectors have made. This will inevitably involve the Treasury putting slightly more money into CQC, but we feel that this is justified when the push for enhanced quality and safety has come in part from the Government.
New models:

CCC will also be affected by the establishment of new models of care and forms of commissioning. Initiatives such as Multispecialty Community Providers and new forms of commissioning, such as that seen in Greater Manchester, will inevitably change the way that CQC operates, as the current model is broadly predicated upon inspection of care homes, GP practices, hospitals and community services. We absolutely accept over the next five years that CQC will have to adapt to changing circumstances but we believe that it would be wrong for the new models to lead to a wholesale expansion in the size of the regulator.

Instead, as the new models will be composed of existing services that are merely working together rather than providing a new service, we see no reason why closer working between the different directorates across the organisation – with a small number of additional staff – cannot enable the regulator to carry out its statutory functions.

In this respect, we were encouraged to read CQC’s Shaping the Future paper, in which it is mentioned that over the course of this year, CQC is planning on inspecting the care received in two different geographical areas across every single service within those areas. The purpose of this work is to flag up health inequalities and unmet need, and we hope that the results of this work is used to shape the regulator’s approach over the course of the next five years.

The new models will also place even more of an emphasis on commissioning than already exists. This will be especially true in relation to models that require care to be commissioned for large population groups, as a poor decision on a commissioner’s behalf could negatively impact upon the care of a whole subsection of people.

We therefore believe that the level of risk that CCGs are taking on, combined with the poor practice that we have constantly alerted both the regulator and central government to since CQC was stripped of its local authority monitoring powers, make it necessary for oversight of commissioning to be reintroduced.

The democratic mandate has never been an argument against the restoration of this power, as oversight of commissioning could only empower the electorate through giving them more information on the performance of the councillors that they elect.
That is not to say that we do not accept the fact that local authorities are under financial pressure; they obviously are. However, they have a statutory responsibility to meet the needs of their local population through responsible commissioning and indeed through the Care Act, have a statutory duty to ensure that their local market is sufficiently enabled to meet the needs of this population. In too many areas of the country, this is simply not happening.

CQC must therefore be given oversight of both CCG and local authority commissioning practices.

Over the next Parliament, we therefore hope that CQC will continue to maintain its same approach, and will keep having conversations with local government and CCGs with regards to how the commissioning process can be rationalised. We do also hope that central government will recognise that funding cannot just come from one source and will fund CQC adequately in order for the regulator to carry out its responsibilities, as well as restoring local authority monitoring powers to the regulator.

Key offer: We will continue to work with CQC as we have done over the last 18 months, as they implement their new regulatory model, and will also work with them in developing their methodological approach to inspecting new models.

Key ask: CQC must be given oversight of local authority commissioning.
**Learning Disabilities**

Providers of learning disability services have the same issues as providers of older peoples services in relation to everything mentioned in this document. When we discuss independent care providers therefore, we refer to services providing care for all population groups.

However, an issue that has affected organisations providing care for individuals with learning disabilities in particular has been the slow progress in moving people from assessment and treatment units into community settings including care homes.

When giving evidence to the Public Accounts Committee in December, Simon Stevens, the Chief Executive of NHS England, stated that he wished to see all assessment and treatment units closed – yet the National Audit Office projected in February that around 2,600 people with learning disabilities remain in such settings. In Board papers published by NHS England in May, it was noted that 650 people had been discharged from inpatient settings into the community.

We are fully supportive of the policy intention of moving people with learning disabilities into community settings if those services have the resource and technical capability to care for these individuals, and through our membership of a number of groups across the Department of Health and local government sector, we have made that very clear.

We have been pleased with what we have heard from senior officials across the Department and NHS England, and are optimistic about the recently published green paper on empowering people with learning disabilities.

Making the legislative rights of these individuals more transparent and shifting the burden of proof so families have to be convinced why their loved one should be cared for in a more restrictive setting, rather than having to convince the clinician why they should be cared for in a less restrictive setting, are positive developments, and we have reflected this in our response.

However, we are realistic and know that it is unlikely that any legislation will be on the statute book within the next year. That is why there is a need for change to begin to happen now. In his report published earlier this year on this topic, Sir Stephen Bubb called for more engagement between commissioners and providers.
As well as calling for the pooling of budgets where necessary, Sir Stephen stated that the commissioning framework should make it permissible for providers to be able to ‘put forward alternative options’ in relation to where an individual should be cared for. Commissioners do not have a monopoly on expertise in this area, and providers have a lot to offer in terms of providing a practical solution to this issue. We will be calling on NHS England to introduce this alternative proposal power to further empower individuals who want to live in less restrictive settings.

Implementing the changes necessary will require provider as well as commissioner input. In the report on Transforming Care for People with Learning Disabilities, written by a range of different national organisations including ADASS and NHS England, a delivery board as well as a number of different workstreams were established. Providers are absolutely key in implementing change and have to be involved in this work, as they will be the ones delivering the services that will enable assessment and treatment units to close.

**Key offer:** Where clinically appropriate, providers will take patients from inpatient units to enable them to be cared for in the communities in which they live.

**Key ask:** Providers should be involved in discussions on how this agenda is progressed and national leaders should do more to take advantage of their expertise.
Dementia

In England, it is estimated that around 876,000 people have dementia. It is also one of the top five underlying causes of death. Furthermore, dementia is the most feared condition amongst middle-aged and older people. A YouGov poll showed that 39% of over 55s fear Alzheimer's more than other disease, in comparison to the 25% who worry about cancer the most.

As well as the human cost, dementia also has an extremely significant economic cost. The Alzheimer's Society project that the condition costs society £26 billion, which is more than the cost of heart disease, strokes or even cancer.

Significantly, whilst a lot of the costs for the three latter diseases are borne by the state – namely the NHS – dementia's position as a social care rather than a health need means that in many instances, the individual or their family will be paying either a proportion or the totality of the high level of care required.

The previous government focused far too much on diagnosis at the expense of care received post-diagnosis. Diagnosis is important, but if it is not followed up by high quality compassionate care, then the diagnosis in itself does more harm than good, as the individual is left with the burden of facing the rest of their life with a degenerative condition, but with no support to face it.

Over the past 20 years, care homes have begun to realise the scale of the challenge and as a consequence, we have seen the emergence of dementia specialist services across the country. However, the care needed by this group is multifaceted, and involves a range of different specialties. We believe that the interaction between specialists in hospital and residents with dementia must be improved, as well as improving access to generalist medical care.

In respect to specialists, telecare can be used to enormous effect here. As in Airedale, teleconferencing units could be installed that link the care home to the hospital and enable specialists to provide advice to care staff in dealing with residents who have dementia. GPs could then provide an enhanced service as detailed under the Proactive Care Programme, to look after the day-to-day healthcare needs of this group. Regular meetings would also take place between consultants, GPs and the care staff to review progress and plan care.
We acknowledge that although this initiative might save money, the fact that the practitioners involved are funded by three different sets of commissioners, would mean that structural factors would make it next to impossible to put into practice under the current framework. We therefore propose that over the course of the next Parliament, we begin to move towards a system in which integrated care organisations commission the totality of the care for individuals with dementia, in order to ensure that incentives are aligned to provide the best care for the individual, rather than the best care for any organisation involved.

Home Instead has developed a City and Guilds accredited dementia training programme for its caregivers. The programme teaches innovative techniques for dealing with dementia. Rather than focus on the symptoms and treatments of the condition, caregivers are trained in effective techniques for managing the many different and sometimes challenging behaviours associated with dementia, including refusal, delusions, aggression, false accusations, wandering and agitation. A key outcome is that caregivers learn to respect the person with dementia as an individual and how to tailor care to their specific needs.

(Taken from Prime Minister’s Challenge on Dementia 2020, The Department of Health)

Key offer: We will continue to innovate in dementia care and expand the opportunity that those living with the condition have to receive specialist care

Key ask: More freedom should be offered to commissioners to pool budgets to enable innovation.
Conclusion

We feel that the next five years have the potential to be even more challenging than the last. Falling fees but rising expectations will cause many prospective innovative providers to question whether to enter the sector, and will cause many already here to wonder whether they should consider leaving.

However, we feel that there is a better understanding of the gravity of the situation that has perhaps not been in place before, and we hope this understanding manifests itself in action that both drives the funding necessary to secure innovation in the provider sector and improved outcomes amongst our service-users.

If it doesn’t, then there is a real possibility that the survival of state funded independent care services will come under question as providers are forced into a position in which they can only accept fees from self-funders. The Care and Support Alliance have noted already that over 500,000 people lost eligibility for state funded support over the last Parliament.

If the changes that we seek do not occur over the next Parliament, it is a real possibility that state funded support might not even be there for those who are eligible for care and support, who are some of the most vulnerable people in our society.

We will do our bit in order to make sure that this does not become a reality, but it is imperative that others follow through to ensure that the excellent, person-centred and compassionate care that independent care services provide remain sustainable for years to come.
Professor Martin Green OBE - CEO, Care England

Martin has had an extensive career in NGO development, and is Chief Executive of Care England. He is also Chair of the International Longevity Centre, a Trustee of Independent Age and the National AIDS Trust. He is the Department of Health Independent Sector Dementia Champion and he was awarded an OBE for Services to Social Care in the 2012 Queen’s Birthday Honours List.

Ann Mackay MBE - Director of Policy, Care England

Ann has worked in the independent social care sector for over 28 years, having started her career as a manager in the NHS. Ann’s work aims to ensure members have up to date information and that their views are represented in the development and implementation of health and social care policy.

Ann was awarded the MBE for Services to Social Care in 2010.

Jamie Balbes - Policy Officer, Care England

Jamie has been working at Care England since October 2013. His professional and academic experience to date include getting a First in History at the University of Manchester and carrying out internships in the Civil Service and at a wealth management company, as well as working in a local GP surgery.

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