Manchester Metropolitan University

Greater Manchester Independent Prosperity Review

Adult Social Care technical report

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Executive Summary

This technical report examines adult social care provision within Greater Manchester (GM). It informs the Low Productivity and Low Pay Research Commission report that supports GM's independent Prosperity Review.[1] It addresses the following question:

- *How should we reform the adult social care sector to provide a more sustainable workforce and maximise service quality and productivity?*

The technical report's emphasis is accordingly on the funding, commissioning and integration of adult social care and their implications for workforce, service quality and productivity; reform of clinical service delivery is not a key feature, other than where it intersects with workforce issues. The technical report also focuses, in line with the Prosperity Review's wider evidence base, on ASC provision in the private sector. Key aspects of the technical report are summarised below.

What do we currently know about adult social care in GM?

GM is embarking on an ambitious programme of adult social care (ASC) transformation that has substantial potential to drive change. This is, however, largely predicated on existing funding and commissioning processes with well-recognised consequences for workforce sustainability. This could be detrimental to the success of the transformation programme.

GM's workforce challenges reflect those across England. Concerns around quality, recruitment and retention are coupled with a growing demand for care workers, in the face of wider competition from other sectors and an ageing workforce. Urgent attention to this, especially the employment deal, is required to ensure high quality adult social care. ASC in GM is also labelled as low productivity, but this is contentious, given its delivery within a cost-constrained context and the acknowledged intensification for its workforce.

National and international models could offer further scope for GM reform. Urgent review of funding models is needed and international examples may be relevant. While it is beyond the scope of this report to recommend one preferred solution, it is beyond doubt that there is a 'burning platform' that should give impetus to action from local and national policy-makers. There are also important choices to be made around commissioning models and again international models offer potential shifts to outcomes-based rather than time and task-based commissioning. Further action on health and social integration is needed, as in

1. https://www.greatermanchester-ca.gov.uk/what-we-do/economy/greater-manchester-independent-prosperity-review

GM and England, this has been largely process focused and limited progress has been made on budgetary and workforce integration.

Current funding and commissioning processes, together with limited health and social care integration, have substantial and negative implications for workforce quality, recruitment and retention. The offer of a much-needed enhanced employment deal must be addressed. Approaches such as self-managed teams might also improve the experience of working in adult social care.

In summary, substantial programmes of reform are underway in GM, but challenges to this are evidenced here in an ongoing reliance on existing funding and commissioning models and the partial integration of health and social care. These present ongoing challenges for workforce sustainability.

What options are there for the strategic direction of ASC in GM?

Stakeholder interviews demonstrate the enormous scale of innovation in ASC in GM. Within the constraints of a single technical report, it is not possible to capture all ongoing innovation and the focus here is on exemplar innovations that centre on workforce sustainability, working towards health and social care integration, outcomes-based commissioning and digital care.

Workforce sustainability could be improved through initiatives including values-based recruitment, team-based working and leadership development programmes. Aspirations that ASC work be properly remunerated were accompanied by recognition of a multi-million funding gap and pessimism as to the likelihood of substantial improvement in employment terms and conditions.

Further integration of health and social care affords opportunities such as multi-disciplinary team working, role re-design and integrated apprenticeships. Overall, progress on meaningful workforce integration appears to be somewhat limited, although small-scale pilots outlined here demonstrate substantial opportunity for role re-design and the offer of more highly-skilled career paths.

Outcomes-based commissioning is being trialled in some areas with positive early signs. There are two key challenges: first, the increased funding required and second, cultural resistance, from providers, staff and care recipients. A substantial amount of ongoing work is needed to deliver the potential benefits.

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Digital care is again being trialled. Despite pockets of highly innovative practice, technological innovation in the social care sector is substantially behind that in the health sector and is an area for further development.

In summary, GM is experimenting with highly innovative practice and further investment could reap dividends, but current processes could pose substantial barriers to success. Mechanisms to support scale up of successful initiatives are needed.

Where do we go from here?

Funding

There appears to be widespread agreement that the current ASC funding system is ‘broken’ and that urgent reform is needed. Reducing demand for ASC and delivering cost and other efficiencies will be an important part of this. However, for the system to truly function effectively it must be underpinned by an appropriate funding model. A number of options are presented in the technical report.

Commissioning

Following devolution, GM has promoted person- and community-centred approaches (PCCA) to care delivery. These focus on delivering outcomes that are important to care recipients and underpin improved care quality. These approaches also offer improved job satisfaction to care workers, contributing to building a stable workforce. Changes in commissioning processes that focus on outcomes are underway but at early stages and will require additional funding. Options are again presented.

Health and social care integration

The devolution of health care budgets in 2015 created the opportunity to accelerate integration of health and social care in GM. It would appear that this has been more successful on some fronts than others, with reasonable progress being made on processes, some progress on budgetary integration, but limited progress on workforce integration.

Further integration is necessary, particularly to direct increased funding to ASC and address the poor image of working in the sector. A number of options are suggested.

Workforce

Low pay and other poor employment terms and conditions coupled with the negative image of working in social care have created substantial labour shortages in ASC. This is despite care work being an intrinsically meaningful occupation that can deliver high job satisfaction. Given that full workforce integration is unlikely in the short term, other mechanisms to address workforce issues are suggested that centre on improving both the employment deal and the status of ASC work.

Digital care

There are pockets of advanced practice in digital transformation in GM, but these appear to be limited as compared to digital health innovations. Developments are suggested.

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The challenges in ASC are varied and complex. Addressing them will require a co-ordinated effort across a range of stakeholders and the options outlined above offer a starting point for this process.

Introduction

This technical report examines adult social care provision within Greater Manchester (GM). It informs GM's Independent Prosperity Review,[2] which in turn forms part of the evidence base for GM's local Industrial Strategy. It addresses the following question:

- How should we reform the adult social care sector to provide a more sustainable workforce and maximise service quality and productivity?

The technical report's emphasis is accordingly on the funding, commissioning and integration of adult social care and their implications for workforce, service quality and productivity; reform of clinical service delivery is not a key feature, other than where it intersects with workforce issues. The technical report also focuses, in line with the Prosperity Review's wider evidence base, on ASC provision in the private sector.

The technical report has three sections. First, it provides an overview of the current state of knowledge on ASC in GM and then draws on national and international evidence to consider alternative approaches. Second, it presents a range of stakeholder views on innovations to inform strategic direction in Greater Manchester. Drawing these together, it presents a series of policy options.

2. https://www.greatermanchester-ca.gov.uk/what-we-do/economy/greater-manchester-independent-prosperity-review

What do we currently know about workforce and productivity in adult social care in GM?

ASC comprises a range of services and support that enables older people, those with learning disabilities, mental health and other needs to live independent, high quality lives. As the population ages and more adults live with long-term conditions, demand for ASC services is rising inexorably, as are associated costs. As a result, existing models of care are deemed to be unsustainable (ADASS NW, 2018b).

Provision and reform of ASC is thus central to policy discussions, locally, nationally and internationally (Malley et al., 2012), with particular emphasis on shifts to home-based care as a means to more effectively support (fewer) people (ADASS NW, 2018b). While sharing the same concern of providing high quality care, social care systems around the world are organised differently. ASC provision in GM is first discussed, before considering alternative national and international models.

The adult social care context in GM

ASC in GM, along with the rest of England, is provided by local authorities. Across GM's 10 boroughs, local authorities offer in-house, short-term re-ablement ASC services and most of the remaining, ongoing provision is commissioned in the independent (private and voluntary) sector. The independent sector thus provides around 80% of ASC in GM.

Provision comprises:

- Residential and nursing homes, with GM providing nearly 18,000 beds that operate at 90–100% of capacity.
- Domiciliary (at home) care, where GM currently supports over 26,000 residents.
- Learning disability services for over 7,400 people (GMCA/NHS in GM, 2018).

The commissioning of ASC in the independent sector follows a 30-year programme of marketisation in the UK public sector. Marketisation was intended to enhance care quality and improve its cost-effectiveness, yet across an extended period of austerity, substantial concerns over quality have grown as funding has failed to keep pace with the demand for ASC. Most care is commissioned through framework agreements, which seek to assure provider quality, and providers then tender to deliver care. Care services are predominantly commissioned on a pay-when-used basis using a time and task approach, rather than a

3. Current pilots of alternative commissioning models are discussed below.

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block basis, and this creates instable funding streams.[3] Further, financial pressures constrain funding rates; in domiciliary care, for example, GM rates are typically below the UKHCA-calculated hourly cost delivery of £18.01 (UKHCA, 2018). There is acknowledgement at national level of systemic pressures and GM similarly recognises the enormous strain on commissioning arrangements in the face of unsustainable funding constraints and instable markets (GMCA/NHS in GM, 2018), where provider withdrawal or the handing back of contracts is markedly increasing (ADASS NW, 2018b).

Acknowledging these pressures, an ASC transformation programme has been established in GM that comprises six priority work streams:

- Living well at home (domiciliary care): aimed at stabilising a market with high quality providers and reducing off-framework purchasing of care services.
- Residential and nursing care: improving quality of care delivery and links to primary care.
- Learning disabilities: improved care quality and support into employment, better family-based care and data-led commissioning.
- Support for carers: offering support, recognising expertise and enabling educational and employment aspirations.
- Workforce: recruitment, development and retention of skilled care workers.
- Supported housing.

The aspiration is to improve support to live well at home, thus reducing need for traditional, long-term residential and nursing care. GM is also participating in Teaching Care Home/ Institute of Care programmes operating at national and borough levels. As evidenced in a later stakeholder interview, workforce is critical to effective delivery of ASC and has recently become the primary focus within the ASC transformation programme. It is accordingly a key aspect of this technical report, with again emphasis on those working in the private sector.

Traditionally, health and social care in GM have been separately managed. Following the 2015 devolution deal, however, GM became responsible for its £6bn spend on health care services, which created opportunity for greater integration of health and social care to deliver more efficient, higher quality services. Led by the Health and Social Care Partnership, GM is now developing an Integrated Care System[4] and each of the 10 localities is establishing a Local Care Organisation. Here all health and social care services outside the acute sector are organised by neighbourhood. Each of the 10 boroughs has teams that comprise medical, nursing and social care leads. Each borough is approaching its governance arrangements independently and the degree of integration varies. In Salford, for example, former local authority workers have been transferred into the employment of the Clinical Commissioning

4. https://www.england.nhs.uk/integratedcare/integrated-care-systems

Group, whereas separate employment arrangements continue in many other boroughs. Front-line care workers across all boroughs however, remain predominantly employed in the independent sector. It is also worth noting that the bulk of health and care budgets are separately managed with relatively small proportions pooled, although again the extent of integration varies by borough.

GM promotes outcomes- and person- and community-centred approaches[5] (PCCA) or asset-based approaches to commissioning (ADASS NW, 2018a). These have been particularly successful in the Wigan borough.[6] Here, outcomes are agreed by care providers in conjunction with care recipients and their families and services are co-designed and co-delivered (Burns et al., 2016).

The ASC workforce is central to this and these approaches to commissioning are considered here to the extent that they are relevant to the workforce. Carers,[7] unpaid and usually family and friends, are central to asset-based commissioning: there are 280,000 in GM, and their support is often poorly recognised and co-ordinated (GMCA/NHS in GM, 2018). Addressing these commissioning challenges affords substantial opportunity to improve service quality and productivity.

5. http://www.gmhsc.org.uk/wp-content/uploads/2018/04/GM-Partnership-Commissioning-Strategy-FINAL-web.pdf
6. https://www.scie.org.uk/future-of-care/total-transformation/blogs/the-wigan-deal
7. Carers are beyond the scope of this technical report, other than later consideration of their contribution to productivity calculations, as the focus is predominantly on the front-line ASC workforce.

Workforce in GM

Successful delivery of ASC depends upon the workforce and their abilities, meaning it is vital to understand skills, size and structure (Hitchcock et al., 2017). Workforce sustainability in GM is a significant issue, again reinforced in later stakeholder interviews. Key challenges comprise workforce quality, recruitment and retention (ADASS NW, 2018b). Central to this are both poor employment conditions and the negative image that typically attaches to care work. These are particular concerns in the private sector workforce, often as a result of commissioning pressures outlined above. Here care workers experience much less favourable employment than those in the statutory sector, where local government terms and conditions typically apply. Private sector care workers are also usually paid less than those in the voluntary sector, as providers here are often able to focus on better-paid types of care package that also offer longer visit times.

In GM, front-line care worker numbers total 64,000 (SfC, 2018), 50,000 of whom are employed in the independent sector (GMCA/NHS_in_GM, 2018). While low pay is a focus of the Prosperity Review, and indeed pay rates are typically at or around the minimum required, other terms and conditions of employment are equally problematic. For example, around 20% of frontline care workers, more in domiciliary care, are employed on zero-hour contracts.

SfC (2018) analysis indicates:

- Only 50% of care workers hold a Level 2 qualification.
- Length of service is 5 years in role and 8 years in the sector.
- High turnover rates, especially for new starters and those new into ASC (usually around one third of new starters):

  Turnover is 24.3%, which is slightly lower than rate for England at 27.8%, and varies by borough from 18.7% to 36.1%. Stakeholder interviews indicate that some of the borough variation may be due to data capture issues rather than lower turnover.
- High vacancy rates of 5%, against the rate for England of 6.6%, with again borough variations from 2.2% to 8.1%.

Qualification rates and levels reinforce the low-skilled perception of the sector. Care work is not, however, low in skill, rather this label applies as the workforce is over 80% female and care is considered to be ‘women’s work’ (Atkinson and Lucas, 2013). It is an important point to address and initiatives to offer workforce development and raise its status are integrated into Teaching Care Home and Institute of Care models that target wider ASC reform. Workforce make up is 90% British, 3% EU and 7% non-EU (SfC, 2018). This suggests

that Brexit may be less of an issue in GM than elsewhere in the country, although stakeholder interviews indicate that the uncertainty it generates is nevertheless a cause for concern. The sector is also over-reliant on older workers which, coupled with being female-dominated, suggests a lack of diversity in the ASC workforce. This is problematic as it again reinforces low-status perceptions of the role.

Poor employment terms and conditions raise questions for workforce sustainability, particularly in the private sector. The SfC (2018) report, for example, demonstrates that, in GM, turnover is lower where relevant qualifications are held and for those with longer service, higher hourly pay rates and guaranteed-hours contracts and for older workers.

At national level, the key role of employment conditions on recruitment and retention has also been evidenced (Atkinson et al., 2018). Recognising this, GM has established a 'workforce deal' for its domiciliary care workforce, for action by both commissioners and providers (KPMG, 2018). It is aspirational and voluntary for local authorities, its key elements comprising:

- Flexibility and benefits: salaried employment, paid travel time, bank holiday uplift.
- Training: 12 weeks paid training, induction and buddying, basic skills, apprenticeship levy.
- Support and progression: apprenticeships and accreditation (age-dependent).
- Perception, leadership and recognition: where perception includes messaging, branding and support to create a positive image, values-based recruitment and education links to promote care work; strong leadership is required by key stakeholders including the Mayor; and recognition is created via events and promotion of ASC achievements.

Additionally, the deal should offer interest free loans for driving lessons and costs and a winter pressures uplift. The calculated net outlay of these measures is £15m over 3 years, with a net benefit to providers of c.£5m. If effective, it would underpin the approximately 30% increase in volume of domiciliary care needed (KPMG, 2018). Funding constraints have, however, meant that the workforce deal has not yet been fully implemented and GM's transformation programme is operating within a context of poor quality employment for the independent care sector workforce.

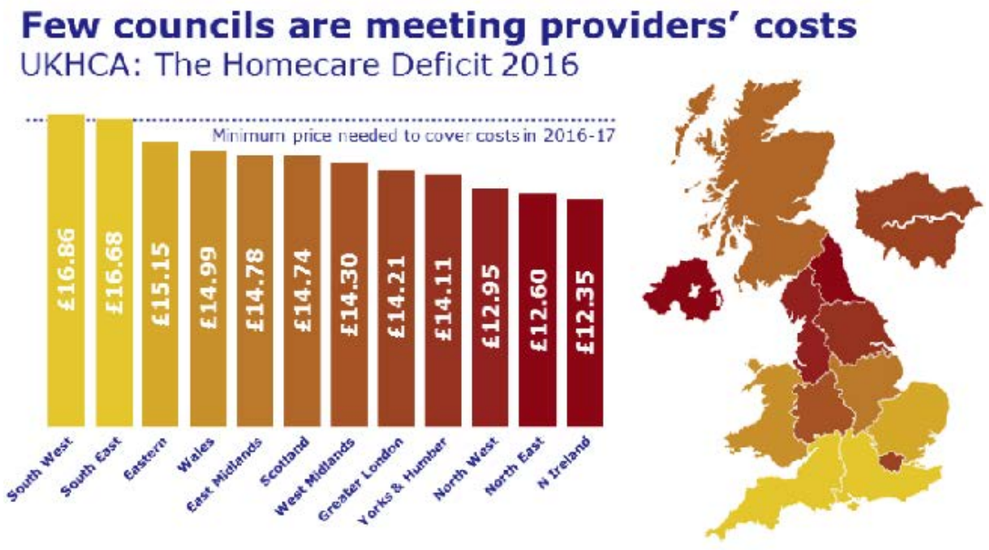
GM's workforce challenges reflect those across England and the rest of the UK. Concerns around quality, recruitment and retention are coupled with a growing demand for care workers, in the face of wider competition from other sectors and an ageing workforce (SfC, 2018). Urgent attention to this is required to ensure high quality adult social care.

Productivity in Adult Social Care in GM

Greater Manchester Combined Authority's (GMCA) 'Low pay and low productivity briefing note' [8] positioned social care as a low productivity sector,[9] with a Gross Value Added (GVA) for health and social care of £31,000. The national figure for adult social care separately is £19,700 (SfC/ICF, 2018). While both are indicative of low productivity, this is a contentious label for ASC, given its delivery within a cost-constrained context and the acknowledged intensification for its workforce. Alternative measures that might better reflect the value of social care are presented separately in a think piece by Manchester Metropolitan University's Decent Work and Productivity Research Centre.[10]

The broader context is one in which GM has low commissioning rates as compared to both the rest of the North West (ADASS NW, 2018b) and to England, particularly in relation to domiciliary care (UKHCA, 2018, Figure 1).

Figure 1: Domiciliary care rates in England



Source: UKHCA (2018) A minimum cost of homecare

8. https://www.greatermanchester-ca.gov.uk/info/20175/research/140/low_pay_and_productivity
9. Sectors at/or around £30,000 GVA per employment are categorised as low productivity.
10. https://www2.mmu.ac.uk/decent-work-and-productivity

At £450 per week for residential/nursing care and £164 per week for domiciliary care, GM rates are the lowest in the North West. Given the substantial anticipated growth in ASC costs, increased financial pressures and provider withdrawal are a substantial concern. ADASS NW (2018b) also questions the extent to which low fees and poor quality are linked. October 2018 figures suggest that 70% of care home have received a good or outstanding CQC rating with the figure for domiciliary care being 86%.

While this is an upwards trajectory, ADASS NW (2018b) has cautioned on emerging problems in maintaining these quality improvements. Certainly, other research has demonstrated the relationship between low commissioning rates and poor quality outcomes, often via the poor employment offer and recruitment and retention difficulties that result (Atkinson et al., 2016; Moore, 2017; Grimshaw et al., 2015).

Emphasis on productivity can also have negative consequences for care delivery. For many years, commissioning has been based on time and task, creating outcomes in domiciliary care such as very short visits of, for example, 15 or 30 minutes. While in one sense this is a very productive use of time and resource, it is nevertheless detrimental to care worker and care recipient experiences. Recent research, for example, has demonstrated that zero-hours contracts and short visits are particularly problematic for subjective dimensions of care quality (Atkinson and Crozier, *Forthcoming*). This begs the question about the balance between efficiency and quality in ASC. Commissioners are increasingly experimenting with different approaches, a point returned to in stakeholder interviews, but spot purchasing on frameworks prevails over block purchasing of care in many boroughs.

To summarise, GM is embarking on ambitious programme of ASC transformation that has substantial potential. This is, however, predicated on existing funding and commissioning processes with well-recognised consequences for workforce sustainability. These factors could well be detrimental to the success of the transformation programme.

What can we learn from national and international approaches?

The ASC terrain is huge and complex. Accordingly, this section considers issues that pertain to the technical report brief, low pay and productivity, and draws on evidence beyond GM. In particular, it examines key aspects of care provision, that is: **funding**, **commissioning** and **integration** (Gori et al., 2016) and considers their implications for **workforce sustainability**.

Taking first **funding**, the GM context outlined above largely reflects England's liberal welfare model that operates a local, marketised and means-tested system for adult social

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care (Petersen and Hjelmar, 2014). Local authorities commission care and funding is locally generated via Council Tax receipts. In the face of substantial funding pressures, local authorities have, since 2016, been permitted to charge a small Council Tax precept that generates additional funding ring-fenced for ASC provision. Additional funding is also provided on an ad hoc basis by central Government, as in the October 2018 budget, in an attempt to relieve pressures. These funding mechanisms are suggested to be inadequate and 'sticking plaster' in nature, with longer-term solutions needed. LGA (2018) confirms that many of the issues faced in GM are reflected across England and other UK nations e.g. Wales (Atkinson et al., 2016), Scotland (Cunningham, 2016) and internationally in countries that have adopted a market-led approach (e.g. US, Australia, Canada and Japan).

Taking first funding, the GM context outlined above largely reflects England's liberal welfare model that operates a local, marketised and means-tested system for adult social care (Petersen and Hjelmar, 2014). Local authorities commission care and funding is locally generated via Council Tax receipts. In the face of substantial funding pressures, local authorities have, since 2016, been permitted to charge a small Council Tax precept that generates additional funding ring-fenced for ASC provision. Additional funding is also provided on an ad hoc basis by central Government, as in the October 2018 budget, in an attempt to relieve pressures. These funding mechanisms are suggested to be inadequate and 'sticking plaster' in nature, with longer-term solutions needed. LGA (2018) confirms that many of the issues faced in GM are reflected across England and other UK nations e.g. Wales (Atkinson et al., 2016), Scotland (Cunningham, 2016) and internationally in countries that have adopted a market-led approach (e.g. US, Australia, Canada and Japan).

There is widespread agreement on the need for reform to England's ASC funding model, but political parties of all persuasions have failed to address this and a long-overdue government Green Paper has been further delayed. A recent LGA (2018) Green Paper suggests paying providers a fair price (to include inflationary pressures and increasing demand) and introducing a cap on care recipient contributions and a more generous lower threshold on the means test. Options suggested for funding this include: taxes on income (tax, NI, council tax), on property wealth, and cuts to other public spending. All this is predicated on continuation of a local model and the LGA Green Paper also questions what the role of local government should be. This reflects wider concerns over the limits of local approaches from nations that have adopted national funding models (Amin-Smith et al., 2018). The Netherlands and most Scandinavian countries, for example, have adopted state-funded welfare system models (Alders et al., 2015; Kroger and Bagnato, 2017). In line with their social justice approaches, care is universally available and free at the point of use. Costs are, however, rising given growing demand and some services have been cut in the face of

increasing financial pressures in, for example, Denmark, Finland and Iceland (Kroger and Bagnato, 2017). In England and GM, there is unlikely to be the political appetite to adopt this model, especially given the scale of cost pressures in the NHS, which relies upon a similar model.

An interesting alternative is Germany's model,[11] introduced about 20 years ago following a cross party initiative on a series of reforms when the country was facing similar issues to England. Responsibility for social care was transferred to national government and a collective social insurance scheme established. Here workers, retired people and employers contribute and all money raised goes into a ring-fenced fund used for adult social care. Access to social care is on the basis of assessed need, rather than means-tested, but only basic needs are covered so some private funding may still be needed. Cost control has been managed, with so far small tax increases despite expansion of cover, but there are of course risks of future increases as demand grows. Mandatory insurance to cover social care costs has also been introduced in other countries including Netherlands, Sweden, France, Japan, though many have again experienced financial pressures (Robertson et al., 2014).

Funding is a contentious and complex matter and there is no single model that addresses all issues. Current GM/English approaches have, however, created unstable provider markets with, for example, a growth in handing back of contracts as these become uneconomic for independent providers (LGA, 2018). Funding pressures have also had substantial implications for care quality, with a number of high profile scandals, and also for workforce quality, recruitment and retention (Atkinson et al., 2016). Urgent reform is clearly needed. While it is beyond the scope of this technical report to recommend one preferred solution, it is beyond doubt that there is a 'burning platform' that should give impetus to action from local and national policy-makers (e.g. Dromey and Hochlaf, 2018).

While debates exist as to national versus local funding, there is general consensus that local **commissioning** is essential to meeting local need. Clearly funding has substantial implications for commissioning practice and financial pressures over recent decades have led, across GM and the rest of England, to emphasis on cost efficiencies. Time- and task-based commissioning has resulted, with practices such very short visits for domiciliary care recipients being seen as highly productive, despite negative effects on both workers and care recipients. Elsewhere in the UK, there has been a regulatory shift to outcomes-based care e.g. Welsh Government (2015), although this is in tension with a continuance of time- and task-based commissioning (Atkinson et al., 2016). Across Europe, asset-based commissioning is also being promoted as part of moves to de-institutionalise adult social care and deliver it in the community (Deusdad et al., 2016; Colombo et al., 2011), e.g. a

11. a. http://www.if.org.uk/2018/03/27/englands-social-care-crisis-germany-answer
    b. http://blogs.lse.ac.uk/politicsandpolicy/german-approach-to-long-term-care-funding

shift from residential to domiciliary care in Netherlands (Alders et al., 2015). It is considered a cost-effective way to deliver care in, for example, Canada and Japan (Park et al., 2014; Tsutsui, 2014).This form of commissioning involves outcomes being agreed by care providers in conjunction with care recipients and their families and services being co-designed and delivered. It does, however, place greater dependence on effective domiciliary care systems, many of which are in crisis. It also raises questions about formal versus informal care and again there is a different balance across countries. Scandinavian countries rely mainly on formal care and informal care is a choice not an obligation (Alders et al., 2015; Kroger and Bagnato, 2017).

This fundamentally differs from the liberal welfare arrangements of the UK, Australia and new Zealand (Petersen and Hjelmar, 2014) where increasing eligibility thresholds force informal care (Atkinson et al., 2016). There is also substantial emphasis on informal care as it is seen to be cost effective (Heger and Korfhage, 2018), although increased labour market participation of women (who traditionally deliver informal care) makes relying on informal care risky, as does the economic dis-benefit of their absence from the labour market. This is demonstrated in the discussion of how to measure the contribution of the ASC system. Clearly there are important choices to be made around commissioning models and a later stakeholder interview presents a pilot within GM that emphasises asset-based commissioning and supports this with an adapted funding model.

Integration of health and social care systems, accounting for all of a care recipient's needs, is fundamental to outcomes-based care. There are however, in most countries, structural barriers to integration, including leadership, governance and IT (Schlaeffer et al., 2017). While this has been the focus of substantial attention in GM and England, integration has been largely process focused. More limited progress has been made on budgetary and workforce integration. Scotland has seen more structural integration with its Health and Social Care Boards and support for community-based integrated care teams (Baird et al., 2014). These have streamlined processes and reduced duplication, but workforce integration has been limited to public sector workers and care workers continue to be employed in the independent sector. Internationally, integration is also process rather than workforce focused, and huge challenges remain in this extremely complex matter.

Funding, commissioning and lack of integration have had substantial implications for **workforce quality, recruitment and retention** (Rubery and Urwin, 2011; Cunningham, 2008). Independent sector providers have transferred risk from low and unstable funding streams to the workforce with a 'race to the bottom' in employment terms and conditions. Further, terms and conditions vary widely across the public and independent sectors with

care workers typically preferring to work for local authorities or even to move into healthcare roles, both of which offer better pay and associated conditions. Even within the independent sector, voluntary providers pay more than private ones, leaving the latter struggling to attract workers. Terms and conditions are thus central to the ASC workforce crisis (Rubery et al., 2011; Rubery et al., 2015; Grimshaw et al., 2015; Cunningham et al., 2014), with evidence that improving these can improve recruitment and retention and positively impact care quality (Atkinson et al., 2018; Atkinson et al., 2016; Rubery and Urwin, 2011). This logic underpinned development of GM's Workforce Deal and, while this may not yet be affordable, there are other national and international solutions.

In the UK, Unison has introduced an Ethical Care Charter. This is voluntary but invites local authorities to adopt it within their commissioning and framework agreements to improve employment terms and conditions. A recent evaluation indicated use of the charter was largely positive in delivering better pay and job satisfaction, reducing turnover and improving care quality (Moore, 2017).

There are, however, cost implications to its adoption and thus far, in GM, only Manchester City Council has signed up to the Charter.[12] Increased funding is again likely to be needed to support widespread uptake but is, in isolation, unlikely to be sufficient. Grimshaw et al. (2015) demonstrate, for example, that only a small proportion of increased funding goes to improve pay and other terms and conditions. In a marketised system, regulation may well be required to establish a floor of employment terms and conditions. Welsh Government acted on this when, in spring 2018, it introduced regulation that provided domiciliary care workers with the right to request guaranteed hours contracts after 3 months employment. While positive, wider reform is also needed as Moore (2017) has demonstrated that care workers are constrained in taking up guaranteed hours where these are inflexible due to both their caring responsibilities and the wider welfare system.

Training and career paths are important to workforce quality, recruitment and retention. In England, integrated health and social care apprenticeships have been advocated as a means to deliver this, although independent providers have expressed concerns that they will be a training ground for other sectors. Indeed, ADASS_NW (2018a) promotes these as a bridge to nursing careers. Lack of workforce integration is again problematic and, while this is experienced internationally, practice in Germany and the Netherlands could offer food for thought.

In Germany, there is a 'two tier' workforce model (Gospel, 2015). One is higher qualified, offering improved status and also a career path from the lower-qualified role. In the Netherlands,

12. http://www.unisonnw.org/manchester_city_council_commits_to_unison_ethical_care_charters

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a model of team-based working called Buurtzog, which means 'neighbourhood care',[13] has been developed (White, 2016). Building on the concept of asset-based commissioning, this offers workers the autonomy to make decisions whilst working closely with patients, taking into account their emotional, physical and psycho-social needs. It prioritises relationship-based practice, improving continuity of care as compared to a task-based traditional model (Nandram and Koster, 2014). Its team-basis offers an effective and efficient way of delivering care (Monsen and de Blok, 2013) that has improved cost effectiveness, enhanced user and staff satisfaction (White, 2016) and reduced burnout (Gray et al., 2015). While developed initially for nurses, it has been extended to social care and serves to improve job satisfaction and offer career progression, in what should be intrinsically meaningful work but which is often dominated by problematic employment practices. Buurtzog reduces the bureaucratic pressures and obstacles of traditional healthcare systems which can reduce productivity (Genowska et al., 2017).

The Buurtzog model has been used with some success (Drennan et al., 2018), although there has been little formal evaluation and it faces difficulties in highly bureaucratic environments. There has also been some criticism of its claims to be more cost effective. A study conducted by KPMG showed that when adjusted for other costs, money spent per patient by Buurtzorg teams was equivalent of national average (Gray et al., 2015). It may, however, be better quality care is offered albeit at a similar cost, in tandem with improving employment quality and alleviating recruitment and retention difficulties.

In this section, the position of ASC in GM has been outlined and alternative national and international models presented. Substantial programmes of reform are underway in GM, some examples of which are presented in the following section, but challenges to this are evidenced here in an ongoing reliance on existing funding and commissioning models and the partial integration of health and social care. These present ongoing challenges for workforce sustainability.

13. https://www.buurtzorg.com/about-us/buurtzorgmodel

What options are there for the strategic direction of adult social care in GM?

This section discusses future strategic direction in ASC in GM. Seven interviews were conducted with a cross-section of stakeholders[14] and the enormous scale of innovation within the sector is apparent from this small number alone. Within the constraints of a single technical report, it is not possible to capture all ongoing innovation and it is recognised that there will be transformation work not reported here. Accordingly, this section has three aims: first, to report exemplar innovations that might be applied elsewhere; second, to recognise the limitations of innovation that operate within current funding and delivery models; and third, to outline the well-recognised constraints of scaling-up 'bottom up' innovation and consider how these might be addressed. Innovations reported centre on workforce sustainability, working towards integration, outcomes-based commissioning and digital care. Stakeholder views on productivity in ASC are also presented.

Workforce sustainability

The pressing need to improve employment conditions as a source of greater workforce engagement with innovation and improvements in care quality is well-recognised (Rubery and Urwin, 2011; Dromey and Hochlaf, 2018). All stakeholders here emphasised deep concerns around workforce quality, recruitment and retention. Indeed, a Health and Social Care Partnership (HSCP) stakeholder indicated that in recent weeks the workforce package of the transformation programme had been made the key priority and suggested that governance would be shaped around it. This was driven by a crisis in labour supply so extreme that some providers were unable to take on care packages. Care providers confirmed it was the single biggest issue that they wrestled with on a daily basis:

> *In the general care workforce, there are high vacancy rates and high turnover. Year 1 is the highest. If people stay for more than 3 years, they tend to stay… We struggle to recruit, but if we don't [also] tackle retention, it's a problem.*

Employment terms and conditions, coupled with the image of care work, were widely held to be central to this, and their implications felt to be wide-ranging. One stakeholder, for example, suggested that:

14. Interviews were held with representatives of: Health and Social Care Partnership (2); Health Innovation Manchester (1); Local Authority Commissioner (1); Skills for Care (1); GM Independent Care Sector Network (1); and an independent domiciliary care provider (1).

> *Innovation is built on the shaky foundations of pay. The KPMG stuff [Workforce Deal report] was very clear about that. Get the workforce deal stuff right before innovation [can work].*

The fragility of the workforce and thus provider markets, with an increasing inability to take on care packages due to staff shortages, was considered to be a substantial threat to innovation. Some questioned the extent to which real progress could be made within current funding arrangements that precluded improvements to employment conditions.

With that caveat, there were a number of workforce innovations that, while in their early stages, were demonstrating promising results. The first of these was adoption of values-based recruitment (VBR). Here recruitment and selection was based around a clear set of values appropriate to the care sector and aimed at ensuring a good fit with it, mirroring Figgett's (2017) work on recruiting for the right values, behaviours and attitudes. This seemed both to attract a high proportion of applicants from outside the social care, as fit rather than prior experience, was prioritised, and to improve retention:

> *We start with the values of the organisation. If we were living these values how would they show within our recruitment process. We look for a good fit with our values, not looking for people with experience or qualifications.*

One stakeholder suggested that, while VBR was becoming a widely used term, it was in practice often not properly implemented. The example of providers claiming to be values-based but still using CVs was an example given. Fuller understanding of VBR is important to deriving its full benefit.

Self-managed teams was another innovation presented as effective in workforce retention, as it offered greater autonomy and improved job satisfaction and supported better continuity of care. Here responsibility was largely transferred to care workers, with some team leader support:

> *The roles that would be done by the manager are instead shared by the team, giving a high level of decision-making power. They do their own rotas, all shared within team. They decide what roles they are going to do in providing person-centred and compassionate care… [This provides] a higher degree of autonomy and team work and provides social support to help deliver a workplace that's more appealing to work in and is more supportive of [worker] health and wellbeing.*

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Self-managed approaches also reduced infrastructure costs and thus increased pay rates for care workers. Providers who operated these approaches noted that the benefits of increased pay were not in isolation, however, sufficient.

> *There is something much more fundamental that needs to change if we are going to attract people outside of health and social care, around the structure of terms and conditions and rotas.*

Vital to recruitment and retention was the offer of guaranteed-hour contracts and wider improved terms and conditions, e.g. flexibility. Those here who had introduced self-managed approaches had also offered, at their own financial risk, guaranteed-hour contracts. It was this broader package of less precarious employment, payment for all time worked and thus paid travel time that was thought to have improved both attraction of applicants from other sectors and retention. This again underlines the importance of an appropriate workforce deal in underpinning sector reform. Some stakeholders noted the increased risk in moving to self-managed team given reductions in control. Having the right staff was essential to its success, going back to the importance of effective VBR.

Leadership programmes to promote skill development and bring about culture change in the care environment were also discussed alongside other initiatives such as teaching care home partnerships:

> *Registered managers [have been] identified as a priority group. They've often found their way into that role with very little support. We've co-designed with providers a RM leadership programme…the idea is to look at a model that will bring in different aspects that are important for RMs in GM – reflective stuff around self and others. Different leadership models… and get them to think about person- and community-centred approaches – creating a culture within the home.*

The logistics of scaling up these initiatives were substantial in both size of task and budgetary constraints given the number of RMs across GM. Other initiatives centred on a planned campaign to improve the image of care work in GM and a pilot to increase the number of single-handed visits. The latter involved improved manual handling training and, if successful, would substantially improve provider capacity in reducing the need for doubled-up visits. This pilot was being replicated from practice in another local authority, again indicating challenges for widely scaling up bottom up innovation. Stakeholders recognised the skilled nature of care work, addressing the needs of vulnerable groups, and noted aspirations that it be properly remunerated. Alongside this, however, was recognition

of a multi-million funding gap and pessimism as to the likelihood of substantial improvement in employment terms and conditions.

Health and social care workforce integration

One stakeholder indicated that every borough should have a workforce strategy that included independent sector care workers, but suggested that most did not. Rather, local authority and clinical commissioning group workforce plans tended to focus on those employed in the public sector. This was problematic, both in addressing (or not) system-wide workforce challenges and in failing to promote fuller integration of health and social care operations. In a number of cases, frustrations were expressed around duplication of effort and inefficiency of historic ways of working:

> *The amount of money that is being wasted with the duplication of effort around district nursing and home care is phenomenal.*
>
> *Need to reduce the number of people coming in – nurses, health visitors and home carers. Some tasks could be done by the same people to save the public purse and also for the [care recipient] less people coming in to the home.*

More positively, however, integration was promoted as having positive outcomes for social care workers, particularly with the operation of multi-disciplinary teams. The negative image of social care work has been raised a number of times already in this technical report and some suggested that closer working might benefit social care in spreading some of the '*shiny image*' that attaches to working in the NHS. Role re-design across health and social care was central to this, with a particular emphasis here on the interface of workers in domiciliary care. Some early-stage pilots were working to transfer some district nurse roles to domiciliary care workers:

> *Looking at the role their home care assistants carry out. They are taking on more aspects of a district nurse role, pressure sores and dressings, working with district nurses to gradually train care workers. We struggle to recruit district nurses, so it's taking pressure off them… We are upskilling care workers and paying them more.*

Here, role re-design and better integration is reducing pressure on another shortage group, district nurses, while providing better paid and higher-skilled work for care workers. No formal evaluation has yet taken place of the pilots, but anecdotal evidence suggests better job satisfaction and improved recruitment and retention. Certainly this kind of re-design

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is central to providing the much needed career pathways in social care, with care workers who carry out previously nursing tasks having the opportunity to work at more senior levels. Careful management of resistance to these changes, particularly around health care staff, has been needed, together with re-design of budgetary and authorisation processes. The level of challenge and complexity around this should not be under-estimated.

Integrated apprenticeships were also presented as a mechanism for creating more formal pathways and improving the image of the sector:

> *How do we create career pathways that cut across both health and social care? We really need to map that out, what are the entry points and requirements so we can look at how it fits together. For the promotion of health and social care as a career – as you know we struggle to get young people in to the sector. We need to show and articulate the opportunities and what they lead to.*

It should be noted, however, that within current structures independent care providers expressed substantial concern about these apprenticeships. While recognising them as a good opportunity, there was also high risk that, in the absence of fully integrated career structures, social care would operate as a training ground and that, once qualified, workers would seek to progress into higher-graded, better paid health care roles. While many providers could see the positives for workers in this, there were nevertheless concerns as to the net benefit for care providers.

Overall, progress on meaningful workforce integration appears to be somewhat limited, although small-scale pilots outlined here demonstrate substantial opportunity for role re-design and the offer of more highly-skilled career paths.

Commissioning of outcomes-based care

In an earlier section, this technical report discussed outcomes-based care and tensions between this and the continued operation of a time- and task-based commissioning model which had led to a 'race to the bottom' in employment conditions. One stakeholder, however, suggested that over the past two to three years, there had been a '*massive shift*' in commissioner understanding of provider markets and a '*race to the top*' in which commissioners were working hard to deliver good deals for independent providers.

Further, stakeholders noted substantial shifts towards outcomes-based, or person-centred, approaches to care and their benefits for workers as well as care recipients:

> *The satisfaction of the teams and the sense of how they work together – in the longer run, it will have increasing potential benefits for the people we support. We are working really hard to make sure that there are a minimal number of people looking after each individual. Each person has a profile of the people who will be delivering their care and we are a relationship-centric organisation so we encourage close relationships rather than discourage them.*

Again pilots are underway in a number of boroughs to adapt commissioning models to support outcomes-based commissioning, and the detail of one is reported here. In this pilot, care is block commissioned around an overall care plan and hours not used can be banked and used elsewhere to offer greater flexibility. The approach is not based on cost savings, indeed it is initially more expensive, rather on managing demand and supporting more people, as fewer care hours may be needed where support is strong. Commissioning rates have increased by around £2.50 per hour and care providers are required to pay care workers £9 per hour. This has been combined with role re-design so that care workers take on additional tasks. Again anecdotally, as the pilot is small-scale and began in February 2018, providers feel that recruitment and retention is improving as is job satisfaction, alongside reduced sickness absence. Providers are gradually developing confidence in the system to offer guaranteed-hour contracts.

While early signs are positive, there are two key challenges. The first is financial. The pilot is currently supported by £3m of GM transformation monies and will experience a predicted £1.7m shortfall if it is to be continued at the end of the current 3 year funding period. In theory, a substantial proportion of the health and social care budget in this borough is pooled and predicted savings to the health care system could enable a transfer of funds from one area of delivery to another. In practice, this was seen to be a '*hard conversation*' to have

with colleagues and concerns over ongoing funding continued. The second challenge is to overcome cultural resistance, from providers, staff and care recipients. It was seen to be difficult for providers who operated in a demanding market, a substantial shift for social workers who had operated in a different model for many years, and for care recipients who were used to a model that specified a particular number of care hours. A substantial amount of ongoing work is needed to deliver the potential benefits.

Digital care

While somewhat beyond the remit of the technical report, interesting examples of digital transformation emerged and are presented briefly here as relevant to the productivity/efficiency of the sector. These are again largely in their infancy but were being piloted with promising results.

Generally the sector was seen to be somewhat lacking digitally, with many care plans, assessments and so on being paper-based. Domiciliary care providers, however, typically provided staff with smart phones that operate electronic call monitoring systems and in some cases rostering systems. Stakeholders called for the wider use of electronic care planning systems that supported outcomes-based care in being easy to update as needs changed and also to share with care recipients and their families. Relatively straightforward developments such as care home-wide Wi-Fi systems would be needed to support this, albeit fewer than a fifth of care homes nationally currently operate Wi-Fi.[15]

Other uses of technology included virtual triage systems (e.g. Skype) in which care home staff can speak to hospital staff to triage a care recipient.

> *If the care team think 'Mary' is poorly and needs a potential transfer to hospital they use the tool to help their decision making process. It will either make a recommendation for managing within the home, or refer to GP or transfer to A&E. It empowers the care home team with knowledge and gives them some governance and assurance around their decision processes.*

This has seen substantial falls in Accident and Emergency admissions and is being rolled out to domiciliary care workers, who will also have tablets to measure blood pressure, heart rate and so on to feed into the triage discussion.

The HIM stakeholder outlined ongoing work in wearable technologies that would be used to support care recipients:

15. http://www.carehomeprofessional.com/exclusive-scie-chair-burstow-calls-wifi-every-care-home

> *We are testing out a different use of technology… and working with an organisation to look at dehydration and fall risks by [using wearable technologies] that track stumbling and sleep. We are looking at how we can use that data to refine our support and make it less likely they need to go to hospital.*

Dehydration and falls are the two biggest causes of hospital admissions for the elderly and reductions in these would have substantial cost benefit.

Despite pockets of highly innovative practice, stakeholders indicated that technological innovation in the social care sector was substantially behind that in the health sector.

Productivity

Few stakeholders were familiar with GVA as a productivity measure. Rather, they argued that common markers of productivity, for example, volume and speed of visits, were not conducive to high quality care outcomes. Instead, a focus on care recipient outcomes and worker job satisfaction were deemed important:

> *We are focused on producing more for less, more visits, more this, more that – but actually it's about culture, leadership and employee wellbeing and how it is measured.*

Metrics that emphasised outcomes over time and task were seen as essential, but complex. Care Quality Commission (CQC) scores, for example, had limitations:

> *What are the relevant outcomes and how do we measure those is an important question. A care home that has a high rate of falls might need to implement a falls risk assessment tool. A best practice example of low rates of falls might achieve that through culture if they don't mobilise their residents so they stay in bed all day. So we need to look at quality of life against accepted degree of risk around falls, but make your CQC scores good. So the measures aren't subtle enough to pick up those things.*

Productivity measures should encapsulate preventative factors, incorporating both health outcomes and subjective satisfaction:

> *So, for community centred approaches, using assets that are already there or don't cost much are inexpensive, it's about service user satisfaction, isolation and wellbeing – all the different things that keep people well and out of hospital. Very hard to measure.*

Employee wellbeing was also presented as a key measure as '*happy staff lead to greater quality*'. Social care image and career paths were important, as productivity is likely to be higher in organisations that can secure and maintain recruitment of a high quality workforce:

> *We need to think differently about productivity – social care is seen as the poor relation. Absolutely key is how to change those perceptions. It's quality of workforce and sustainability of recruitment that impacts on that. It's how you transform the image of working in social care.*

The employment deal was again seen as central to this, workers needing to earn a living wage and have stable working hours. Zero-hours contracts, for example, often meant that staff sought higher call volumes to maximise incomes, but that this could be detrimental both to their and care recipient experiences.

A great deal of further work was seen to be needed in capturing measures of productivity to demonstrate how different skill sets map to care quality outcomes in different care settings:

> *A workforce planning study would be one way of generating evidence for support – if you could evidence that, band 3 and 4s – competencies and capabilities to align with those working with different patients. Dementia care home is a classic example – it is going to look very different from classic residential care home.*

To summarise, care recipient and care workers measures were seen as much more important measures of sector effectiveness than GVA.

Scaling up innovation

The challenges of scaling-up local innovation are well-recognised and encapsulated in SCIE's (2018) recent report on innovative models of care. In essence, while local, bottom up innovation is central to driving change that meets need at local level, the size and complexity of health and social care systems are problematic when seeking to extend these innovations. Of particular note are funding pressures, outdated commissioning models, lack of leadership and lack of skills and capacity.

This section has presented detail on substantial innovation in various boroughs, the question being how to ensure that GM more widely benefits from the success of this innovation. As the SCIE (2018) report notes:

> *To get to the point where these models become part of the mainstream, there will need to be braver decisions about how local resources are spent, with money being transferred over time from low-quality, low-outcome services to impactful innovative models of care.*

SCIE (2018) goes on to recommend:

- Innovation funding, which supports double running costs if plan in place to extend pilot to the mainstream.
- Capacity building including action learning networks for both leaders and workforce.
- Developing appropriate measures and tools that compare social and financial outcomes and support evidence-based decisions.
- Paying providers to deliver outcomes such as improved resilience, independence and self-care.

Additionally, technological solutions may be of value. For example, platforms that share innovation and good practice enabling their uptake by a range of stakeholders.

To sum, GM is experimenting with highly innovative practice and investment in scale up activity is likely to reap dividends.

Where do we go from here?

This technical report has examined ASC provision within GM. It considers sector reforms that could provide a more sustainable workforce and maximise service quality and productivity. This evidence is now used to propose policy options that deliver varying levels of reform, from those aimed at the 'paradigm shift' in funding, commissioning and integration[16] recently called for by the Chief Executive of Care England, to those of more modest ambition. This report has also noted the extent of innovation already underway in GM and the challenges of scaling this up, and mechanisms to support this are incorporated into each section.

The fundamental premise of the technical report is that GM innovation is currently based on the 'shaky foundations of pay' and that funding and commissioning reform and further health and social care integration, however conducted, should support improved workforce terms and conditions and image that underpin improved care quality and productivity, however measured. This is echoed at national level by a November 2018 IPPR report:

> *The challenges of recruiting and retaining workers in the sector is inextricably linked to low pay and poor working conditions. This is itself related to the under-funding of social care and a commissioning and delivery model based on cost not quality. Providers have competed by driving down pay and conditions, and they have faced little resistance given the limited bargaining power of the workforce and the limited enforcement of employment rights. These factors are combining to create a social care workforce crisis. If we are to solve the workforce crisis, we need to deliver a sustainable long-term funding settlement for social care and a transformation of the social care workforce model. This should be based on the establishment of decent pay and terms and conditions through sectoral collective bargaining, and a professionalisation of the social care workforce. These measures would help ensure high-quality work for care workers, and high-quality care for those who need it (Dromey and Hochlaf, 2018: 1).*

Funding

There appears to be widespread agreement that the current ASC funding system is 'broken' and that urgent reform is needed. Reducing demand for ASC and delivering cost and other efficiencies will be an important part of this. However, for the system to truly function effectively it must be underpinned by an appropriate funding model. It is beyond the scope of this technical report to recommend a particular model, but options include:

16. http://www.carehomeprofessional.com/care-england-conference-care-england-chief-urges-government-deliver-integration

- GM to lobby government for a nationally-led funding system, for example, a social insurance scheme similar to the German model.
- GM to use its devolved powers to establish its own funding system, for example, a social insurance model.
- GM to increase Council Tax precepts to provide funding increases.
- GM to increase the transformation budget to support scale up of innovation within current funding arrangements.

The first two options have the capacity to deliver the secure, long-term funding required to underpin an effective ASC system. The third and fourth do not and substantial reform will constrained by these shorter term, less secure funding arrangements.

Commissioning

Following devolution, GM has promoted person- and community-centred approaches (PCCA) to care delivery. These focus on delivering outcomes that are important to care recipients and underpin improved care quality. These approaches also offer improved job satisfaction to care workers, contributing to building a stable workforce. Changes in commissioning to support this are underway but at early stages. Options here include:

- Continuing the shift away from time- and task-based commissioning processes to those that support outcomes.
- Increasing transformation funds to support the (initially at least) increased costs of commissioning.
- Processes to enable better transfer of budgets across health and social care.
- Service provider and care recipient education in PCCA care delivery.

Scaling up of innovation in commissioning requires payment to providers for delivering outcomes such as improved resilience, independence and self-care.

Health and social care integration

The devolution of health care budgets in 2015 created the opportunity to accelerate integration of health and social care in GM. It would appear that this has been more successful on some fronts than others, with reasonable progress being made on processes, some progress on budgetary integration, but limited progress on workforce integration. Further integration is necessary, particularly to direct increased funding to ASC and address the poor image of working in the sector.

Options include:

- Complete integration of health and social care budgets to support more strategic use of funding.
- Partial but increased integration that offers more effective mechanisms to support transfer of budgets to where most effectively deployed.
- Fully integrated health and social workforces, with standard employment conditions and integrated career paths to enable movement and progression within and across sectors.
- Workforces are not integrated but each local authority has a workforce strategy that incorporates both public and independent sector workers.

More integrated deployment of both budgets and workforce is needed. While options one and three offer this, cost and system constraints are likely to prevent implementation. The moves towards integration offered by options two and four are fundamental to system reform and effectiveness.

Workforce

Low pay and other poor employment terms and conditions coupled with the negative image of working in social care have created substantial labour shortages in ASC. This despite care work being an intrinsically meaningful occupation that can deliver high job satisfaction. Given that full workforce integration is unlikely in the short term, other mechanisms to address this include:

- Adoption of the GM Workforce deal.
- Adoption of Unison's Ethical Care Charter.
- Regulation to improve terms and conditions, e.g. the right to request guaranteed hours contracts.
- Health and social care-wide role re-design that offers more skilled roles to care workers and underpins the career paths proposed above.
- Promotion of values-based recruitment and self-managed working to develop more skilled, autonomous roles.
- Development of a more diverse workforce, particularly male care workers, to reduce the low status attached to care as 'women's work'.
- Capacity building for both leaders and workforce to support innovation scale up.

The first three options offer different ways to improve low pay and other terms and conditions in ASC work. The last four mechanisms aim to improve the image of ASC. In combination,

these could substantially improve workforce supply and quality. A call also emerged for workforce productivity to be measured in ways other than GVA, and further consideration of this is needed.

Digital care

There are pockets of advanced practice in digital transformation in GM, but these appear to be limited as compared to digital health innovations. Options here include:

- More investment in basic digital infrastructure; for example, Wi-Fi in care homes, and care planning and assessment technology in domiciliary care.
- More investment in advanced offerings such as wearable technologies.
- Technological solutions to support scale up, for example, platforms that share innovation and good practice enabling their uptake by a range of stakeholders.

The challenges in ASC are varied and complex. Addressing them will require a co-ordinated effort across a range of stakeholders and the options outlined above offer a starting point for this process.

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