Sustainable Social Care Procurement

This report presents the findings from a project which sought to identify opportunities for enhanced competitiveness and to open new markets through business to business collaboration between SEHTA (South East Healthcare Technologies Alliance) and SESCA (South East Social Care Alliance)

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SESCA South East Social Care Alliance
Developing social care for all

SEEDA SOUTH EAST ENGLAND DEVELOPMENT AGENCY
Working for England's World Class Region

SEHTA improving health increasing wealth

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About this report
This report has been commissioned by the South East England Development Agency (SEEDA), as part of its Business Support and Enterprise strategy, and in particular its Public Procurement initiative. SEEDA commissioned the South East Healthcare Technologies Alliance (SEHTA) to deliver the research project, and it has been developed in partnership with the South East Social Care Alliance (SESCA), and the Department of Health's representatives in Government Office of the South East (GOSE). This project has been funded by SEEDA.

About the author
Anne Hartnell began championing this initiative with Norman Hambleton of SEEDA and David Parry of SEHTA about 4 years ago. Anne has been instrumental in initiating and driving developments and, as project manager and author of this report, she has played a pivotal role in bringing this project to fruition.

With contributions from:
Section 2 & Appendix IV: Dr David Parry – CEO, South East Healthcare Technologies Alliance (Sehta)
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Appendix II Part 1 - National Minimum Database – Social Care: A profile of the Workforce (2007): David Cubey, Regional Development Officer, Skills for Care

Care provider consultations and sector expertise from:
Board directors - South East Social Care Alliance (SESCA)
SESCA members and their teams, particularly:

- Berkshire Care Association
- Hampshire Care Association
- Independent Provider Forum
- Kent Medway Care Alliance
- Milton Keynes & Bucks Care Association
- SECAS Limited (MKOB)
- Oxfordshire Employers' Forum
- Surrey Care Association
- West Sussex Forum

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FOREWORD

Reviews into the provision of adult social care have raised major concerns about the future costs of care with the impact of demographic pressures. The challenges to be faced lie in the increasing numbers of older and disabled people and rising expectations of services; tightening eligibility criteria for care excluding many needy people from support; the impact of charges and means-testing on access to care for those with moderate levels of wealth needs to be addressed.

The Department of Health is expected to publish a Green Paper setting out proposals for the long-term reform of adult social care funding early in 2009. In October 2008, the Department of Health published its guidance on transforming social care in 'Putting People First'[1]. This was followed in January 2009 by the publication of the "Transforming Community Services"[2] report, designed to improve all healthcare services, including better commissioning by NHS and PCTs[3] and greater responsiveness to patient and community needs. The Report "High Quality Care for All"[4] produced by Lord Darzi in June 2008 makes a number of recommendations including giving people a greater degree of control and influence over their health and healthcare.

There is a need for greater integration of clinical and social care provisions. All the reports emphasise the need for engagement and consultation with partners and especially feedback from those with direct contact with patients and people who use services.

Adult social care is a public service mainly delivered by private sector SMEs[5]. National Department of Health statistics show that approximately 76% of registered care provision now lies in the private sector with only 25% of adult social care funded by local authorities, yet the Sector Skills Council for social care (Skills for Care) is still understood to be – and organised as - a public sector employer representative body.

Misconceptions have arisen through policy-driven evolution, sector fragmentation and the focus on statutory commissioning. Whilst there are statutory provision requirements for both commissioners and providers, there has been a gap in full representation of the developing self funding market with private individual buyers of adult social care set to become the largest single commissioning group. They are not driven by the same financial constraints as public sector commissioners and are a fertile market to drive innovation and needs-based training that is already improving the quality of care.

This reflects the Department of Health's model for the future, with most care providers already subject to competition and with private buyers exercising their freedom of choice on where and how they spend their money.

Fragmentation of a private sector dominated by SMEs makes strategic engagement difficult for the public sector. The creation of SEHTA[6] and SESCA addresses this issue in the South East of England. They were formed to promote their respective sectors' commercial interests and together they provide a market-led, business driven, commercial opportunity for introducing telecare and other technologies, which is the basis for this SEEDA project. It had been found that telecare companies have problems selling technology and whilst there is a low take up by adult social care providers. The latter is a growth

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089665
[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197
[3] PCTs = Primary care trusts
[4] http://www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm
[5] SMEs = small and medium sized enterprises
[6] See Explanatory Notes below for an introduction to SEHTA and SESCA

sector with businesses wishing to invest in technologies whilst working in partnership with the public sector.

This report is groundbreaking in the way available information has been used to segment and provide a benchmark for the adult social care sector. Industry information has not been compiled in this way as it identifies opportunities and barriers for telecare technologies. It also provides a comprehensive statistical breakdown for both adult social care and telecare in the South East as a whole and by area, supplemented by feedback from care providers. This project has already generated interest from the public sector which sees the need for all stakeholders to work together if we are to meet future challenges.

The project aims to improve the delivery and quality of care through the use of assistive technologies for people who use services through the following actions:

- SEHTA - to design and/or sell telecare technologies;
- SESCA - to introduce telecare technologies into service delivery;
- SEHTA & SESCA - to have greater input and influence over care policy and strategies.

Norman Hambleton Sector Relationship Manager SEEDA www.seeda.co.uk	Dr David Parry CEO – SEHTA www.sehta.org.uk	Mike Roycroft Chair – SESCA www.socialcarealliance.org.uk

Dated: 31st March 2009

EXPLANATORY NOTES

SEHTA (South East Healthcare Technologies Alliance)
The South East of England is one of the main regions in the world for healthcare technologies. SEEDA provides support through SEHTA, a sector consortium with membership mainly drawn from business to facilitate profitability and sustainable growth of companies in the region.

Telecare is a key area that offers some solutions to the problems related to an ageing population and forecast demands on resources that cannot be met by current provisions. The global market for telecare is estimated at £10 billion per annum by 2010.

In response, a Telecare Knowledge Network has been created, supported by TSB[7] & SEEDA, with plans for a Science and Innovation campus in Telecare. Also, a Telecare cluster for the Greater South East was formed in November 2008 to include 63 companies, employing 3000 people with £600m revenues.

SESCA (South East Social Care Alliance)
The South East of England has the largest regional adult social care sector in England, generating £10.16 billion annual revenue, with its 5,500 care organisations representing 19% of all national providers. Of

[7] TSB – Technology Strategy Board (http://www.innovateuk.org/)

these, 4,500 are registered[8] care providers employing 145,000 staff (113,000 full-time), plus approx. 1,000 unregistered providers offering additional services. 92% of all care services are delivered by the independent sector (private and voluntary) with the private sector accounting for the vast majority (ie 76% of all registered services).

These are commercial enterprises which need to be competitive and respond to demand. Adult social care is a growth sector with many changes taking place. Providers are keen to invest in new technology but take up is low because of external barriers and lack of understanding by commissioners.

Self funders are overtaking local authorities as the main generators of revenue yet smaller private providers have little influence other than by the care associations through local authorities. As with the voluntary and 3rd sector providers, engagement tends to be with larger, often national, providers.

An informal approach was made to SEEDA in July 2008 to explore opportunities for introducing new technologies, coupled with the wish to have a formal seat at the policy table without compromising existing stakeholder relationships. The outcome was affiliation to SEHTA and the formation of SESCA (South East Social care Alliance) as a community interest company social enterprise. SESCA is modelled on a sector consortium and it comprises, and seed funding has been provided by the region's care associations.

SEEDA (South East England Development Agency)
The South East England Development Agency (SEEDA), as the Regional Development Agency for the South East, is responsible for the sustainable economic development and regeneration of the South East of England - the driving force of the UK's economy. Set up in 1999, it is responsible for the economic and social development.

The economy of the region is the 22nd largest in the world, bigger than several countries including Denmark, Austria, Sweden, South Africa, Singapore and Greece. As home to over eight million people, it is the largest region in the UK - bigger than Scotland, Wales and Northern Ireland combined, and covers the sub-regions of Berkshire, Buckinghamshire, Hampshire, the Isle of Wight, Kent & Medway, Milton Keynes, Oxfordshire, Surrey and Sussex.

SEEDA's aim is to create a prosperous, dynamic and inspirational region by helping businesses compete more effectively, training a highly skilled workforce, supporting and enabling our communities, while safeguarding our natural resources and cherishing our rich cultural heritage. SEEDA aims to be a catalyst for change within the South East, working with partner organisations - businesses, education at all levels, local authorities, Government agencies, voluntary and community organisations and many others - to produce clearly recognisable results.

Funds from Government enable direct investment in a range of economic and social development programmes, and are in a position to help secure European Union and private sector investment for the region. Accountable to Government, SEEDA is a business led organisation, governed by a Board whose Members have wide-ranging experience in industry and commerce, local government, education, trade unionism and voluntary service.

[8] Registered and inspected by the Care Quality Commission (formerly CSCI)

EXECUTIVE SUMMARY

Introduction

In the South East of England, the adult social care sector and the telecare industry have sizable, private sector SME[9] communities, each making significant contributions towards regional GVA[10]. However, both sectors have experienced similar barriers to growth through the lack of opportunity for direct, commercially viable collaboration. This has been due in large part to public sector procurement protocols, to the use of intermediary bodies to purchase 'on behalf' of care providers using public funds, and to the methods used to define and implement Government policies and strategies for health and social care services.

> Private sector care providers base business decisions relating to adopting technologies on Return on Investment measures, as well as the impact on competitiveness, efficiencies, and the quality of care services. For those operating primarily in the free market, this has created an environment which fosters innovation and demand-led procurement.

As the project's sponsor, SEEDA[11]'s interest focused on addressing issues affecting economic development and business prosperity. As a result, this project examines the barriers facing these two sectors from a private sector viewpoint; it identifies opportunities for growth, and recommends actions to exploit these opportunities.

The Purpose

The purpose of this SEEDA's funded research project is:

- to identify opportunities to apply assistive technologies through direct business to business, commercially viable collaboration between the social care and telecare industries. This is to be facilitated by the respective industries' regional representative bodies, ie SEHTA (South East Healthcare Technologies Alliance) and SESCA (South East Social Care Alliance),
- to pinpoint the barriers inhibiting the exploitation of these opportunities and to propose solutions,
- to recommend actions to develop and deliver on these opportunities, and
- to provide benchmarking data for both sectors to enable future improvements in productivity and competitiveness arising from exploiting these opportunities to be measured.

The Sectors

- **Adult Social Care in the South East Region**

The adult social care sector helps people aged 16 and above who need extra support, or vulnerable people, to live as independently as possible.

In England, adult social care is predominantly a private sector industry which delivers a public service.

Nationally, approximately 90%[12] of services are provided by independent[13] sector suppliers. The South East of England is home to 19% of the nation's adult social care providers and their annual revenue is £10.16 billion. The 4,500 registered care providers employ 145,000 staff (113,000 full-time). In addition, there are and approx 1,000 unregistered services. In the South East, 92% of all care services are delivered by the independent sector (private and voluntary) with the private sector accounting for the

[9] SME = Small & medium sized enterprises; ie small firms with fewer than 50 employees, & medium sized firms with 51-249 employees
[10] GVA = Gross value added
[11] SEEDA – the South East England Development Agency
[12] Source: Key issues is social care – CSCI Feb 09. 91% of care homes and 82% of domiciliary agencies operate in the independent sector
[13] Independent sector is the collective term used for the private and the voluntary sectors, when taken together

vast majority (76% of all registered services). The statutory[14] sector is a minority employer, providing only 6% of services.

- **Telecare in Greater South East Region**

The telecare industry produces sensor and information and communications technologies for use in the delivery of care and support to people in the chosen 'home' environment to allow them to live as independently as possible.

In the Greater South East[15], the telecare industry consists of 63 telecare technology companies generating revenue of more than £600 million, plus 17 universities which are involved in telecare research. In addition, the South East region supports a cluster of most of the world's biggest telecommunications companies and it possesses expertise in the manufacture of computers and other information-processing and electrical equipment, 'smart' medical / surgical / orthopaedic appliances, software and hardware consultancy. The estimate of the potential market in the South East region for telecare services is currently £1.1 billion per annum.

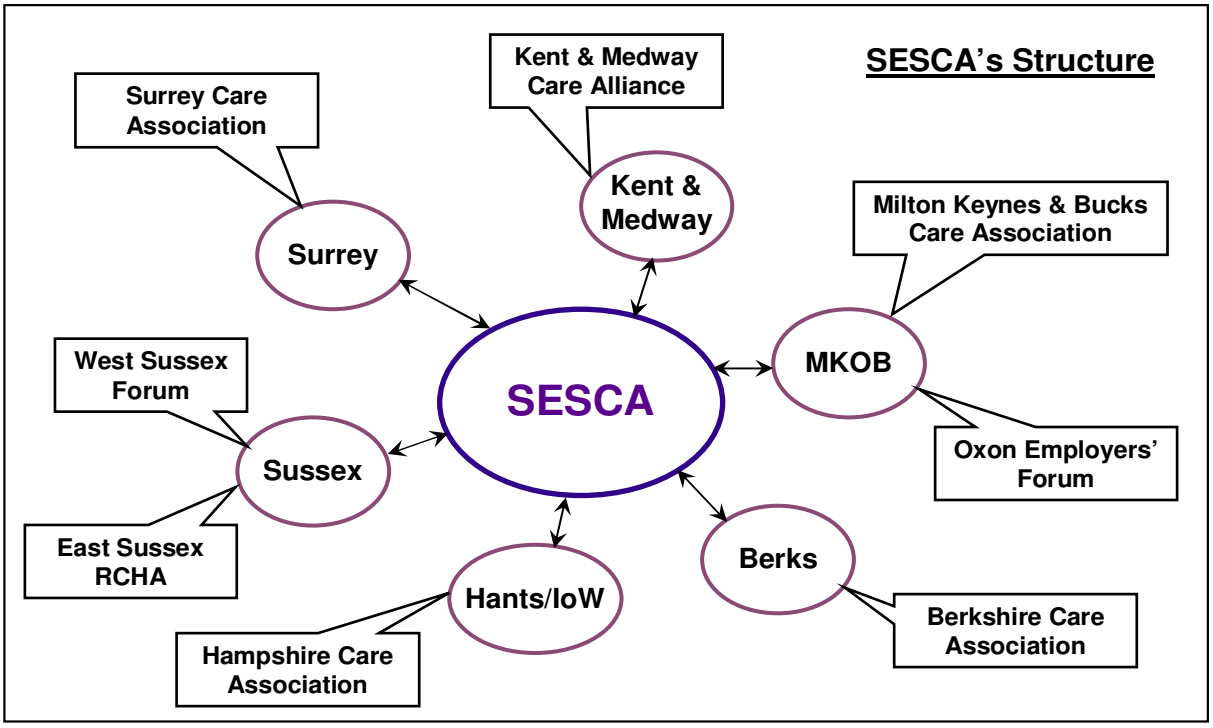
The Delivery Partners

- **The South East Healthcare Technologies Alliance (SEHTA)**

SEEDA supports the healthcare technology industries in the region by funding SEHTA, a sector consortium, which provides its members with access to business development opportunities and promotes their interests to policymakers, regulators, the media and the general public in order to improve the environment in which they operate.

- **The South East Social Care Alliance (SESCA)**

The South East Social Care Alliance (SESCA) is a unique community interest social enterprise, run for and by independent care providers, with representatives nominated and elected through the region's care associations.



[14] Statutory sector = public sector providers (eg local authority & NHS run services)
[15] Greater South East is a term used to describe London, South East and Eastern regions together

SEEDA's interest in the adult social care sector was predicated on an understanding that it is a SME-dominated, private sector industry, it is a key engine of the economy both as a GVA contributor and as a mechanism to release economically active people into the region's workforce, but it operates in an environment which is not conducive to innovation and business improvement. With no pre-existing 'sector consortium' to work with, this project has been the catalyst for the incorporation of SESCA as a social enterprise formed on sector consortium principles.

SESCA's mission is to:

- influence Government policy and strategy at national and regional levels
- to promote and support providers in the independent sector, and
- to collaborate with Government departments and NDPBs[16] with a shared interest in ensuring care provision meets demand effectively.

- **South East England Development Agency (SEEDA)**

SEEDA has a close relationship with SEHTA and, together, they have a reputation for achievement on behalf of the telecare and telehealth industries. SEEDA provides support through SEHTA, a sector consortium with membership mainly drawn from business to facilitate profitability and sustainable growth of companies in the region.

SEEDA's relationship with SESCA is based on:

- A shared focus on business support, innovation & economic prosperity:
  - care is a growth sector dominated by SMEs in the private and voluntary sectors
  - it employs a significant BAME[17] community and provides opportunities for women entrepreneurs
  - it generates over £10 billion in revenues for the region, but
  - care employers have poor direct links to their Regional Development Agency, with reliance on local authorities and public sector driven forums and agendas.

- Providing direct links to key Central Government Departments (DH, BERR & DIUS[18]):
  - the South East has the largest care industry of all the English regions
  - its economy means the care market is dominated by private sector purchasers, with up to 85% of provision being supplied to self funding individuals
  - for Government departments, it is the region where innovation and public-private partnership must be successful.

- A shared interest in improving quality and exploiting business opportunities:
  - interest in supporting a sector with ambitions to introduce technology but which is being held back from doing so in the current environment.

Overview of the Methodology

SEEDA commissioned SEHTA to undertake the project, and to achieve the deliverables over a 5 month period from November 2008 to March 2009. SEHTA established a strong relationship with SESCA as the project required collaboration. The project was managed through a steering group made up of representatives from SEEDA, SEHTA and SESCA.

[16] NDPBs – Non-Departmental Public Bodies
[17] BAME – Black, Asian and Minority Ethnic
[18] DH: Dept of Health, BERR: Dept for Business, Enterprise & Regulatory Reform, & DIUS: Dept for Innovation, Universities & Skills

SEHTA contributed to the project's report with research on the telecare industry, and members of SEHTA participated in the joint workshop with SESCA to explore the opportunities identified through the project's report. Findings from this workshop are included in the conclusions and recommendations.

SESCA provided the majority of the input into the research and the report. They contacted 6% of registered care services to gather views and statistical data. In a two week period in early January 2009, using the local care association network as the route to engagement, SESCA delivered 276 completed questionnaires – an outstanding achievement and clear evidence of SESCA's ability to access and communicate with the SME care provider community. This consultation involved a cross-section of types of care services to ensure inclusion and give as representative a sample as possible of this complex market.

Government Office of the South East's Department of Health representatives were invited to participate in the consultation, and to collaborate in implementing the recommendations. This dialogue is on-going. A route to engaging local authorities on this agenda could be through SEEDA's area directors. The economic development issues raised by this project would most appropriately be integrated into the Local Area Agreement developments and through Business Link and support services across the region.

A collaboration between SESCA and SEHTA is the ideal vehicle for identifying opportunities and for opening new markets by developing and exploiting this demand-led relationship. SESCA is able to engage directly with the businesses who deliver care services to the customer, whilst SEHTA have access to the expertise and technology of companies involved in the assistive technologies industry. These relationships and opportunities could have potential to become sustainable and to expand into regional, national and global markets.

The Project's Findings, the Issues facing businesses, the Barriers to technology adoption, and the Solutions, Recommendations and Next Steps

- **Key findings**

The following are the key findings from the consultation with 276 adult social care providers:

- the providers range from those who offer one type of service exclusively, to those who offer multiple services;
- 91% have been in business for more than 3 years, with 66% having been in operation for over 10 years;
- the main customers for social care are:
  - private individuals (so called 'self funders'),
  - local authority commissioners, and
  - the health/NHS (largely through PCTs);
- local authority commissioning and self funders generate similar levels of income (40% and 38% of turnover respectively[19]), with health generating 22% of turnover (refer to Footnote 19 below);
- 62% are developing or growing their services in the next 12 months, including:
  - changing or diversifying their services in response to market demand;
  - expanding their provision, including moving into niche provision;
  - refurbishing their facilities;
  - implementing cost management measures.

[19] These figures are for guidance only. They are likely to be distorted because the survey covered a cross-section of types of services, including those which only local authorities purchase, and no adjustment has been made for the legacy effects of sell-offs from public to private ownership

- Unlike many public sector procurement protocols, commercial viability based on Return on Investment (RoI) is crucial for private sector providers as part of the decision-making process relating to adopting assistive technologies;

- 78% of respondents stating that they would like advice on appropriate technologies, including telecare, telehealth and telemedicine technologies.

- **Issues affecting business performance, and suggested solutions**

The 'Top 6' issues detrimentally affecting social care business performance over the next 2 years are:

1. Relationships with public sector commissioners (ie local authorities and PCTs) (including policy changes, contracting issues such as funding levels, the urgent need for equitable, meaningful dialogue)
2. Business Development: (particularly the lack of specialist expertise to develop the business and to improve efficiency/quality/ICT/Carbon footprint or source care technologies / Investment funding)
3. Increased competition
4. Market changes: (including issues relating to changes in the customer base, ability to fill beds & responding to more complex client needs)
5. Staff issues: (including turnover levels, salaries, recruitment, training, CRB, immigration changes)
6. Regulation: (including the amount of regulation, the rate of change, the inconsistent interpretation and implementation, and the lack of timely and meaningful consultation).

- **Solutions**

Adult social are providers identified two main solutions to the issues affecting business performance:

1. A more open, equitable and realistic dialogue about policy, commissioning and regulation

Issues relating to public sector commissioning, policy developments and regulation are the major issue for the industry with the strongest message relating to the level of funding not matching the level of need or the ever-increasing demands for quality improvements and flexibilities.

2. Improve Competitiveness

The industry is keen to address the issues relating to business competitiveness by implementing enhanced management processes to enhance efficiency, as well as making changes to improve quality and responsiveness to clients' needs. The consultation shows that there is an overwhelming recognition that technology is valuable to business efficiency, with 92% of respondents agreeing it had improved performance. In addition, there is a strong desire to find out more about appropriate technologies, with 78% of respondents stating that they would like advice on appropriate technologies.

3. Reposition demand-led skills and staff development initiatives to be independent sector-led:

The sector requires a more interactive relationship with training providers and funders so that employers can better define the training their staff require, particularly with the changing needs of the people who use services. As a conduit for this engagement, the region's care associations have a track record in delivering high impact skills and business support services (eg South East Care Advice Service – SECAS – a Learning and Skills Council funded brokerage). This was an excellent model which evidenced the achievement of service improvement and increased take-up of learning and staff development through its evaluation. This service needs to be reinstated. To complement the offer from this holistic service, there is a need for more provision offering 'higher level' business development, including professional advice on technology. Also, skills required for using technologies should be fully integrated into all social care roles and competency frameworks. At the moment, there is no sign of Skills for Care doing this work.

The main agency charged with articulating the sector's skills needs is Skills for Care, the Sector Skills Council (SSC) for adult social care. However, this organisation is still understood to be a public sector SSC. As a result, it is run on public sector principles, and it is perceived as a 'top down' delivery agent for the Department of Health. This need to change immediately and, through the Sector Skills Council relicensing process, Skills for Care needs to reform to better reflect and engage with its constituency.

- **Barriers to adopting technology in adult social care**

Adult social care providers were asked for their views and experiences of care-specific technologies (ie telecare, telehealth and care-specific business tools). Their comments expressed:

Experiences of being discouraged or receiving disincentives for adoption

This significant barrier to adoption results from the following experiences:

- CSCI inspections deeming telecare to increase the 'risk' as part of risk assessment;
- local authorities disincentivising independent sector providers by, for example:
  - restricting access to demonstrators and other publicly funded technologies,
  - focusing on local authority staff and statutory services as beneficiaries for telecare pilots and publicly funded projects, and
  - suggesting that domiciliary care service contracts could be funded on contact time reported by telecare systems, with the implication that fees could be reduced to exclude travel time and other opportunity costs.

Concerns about the ethical, social, and cultural issues relating to technology

A number of concerns need to be explored, particularly to see if perceptions can be challenged and/or addressed.

Many existing telecare technologies require a level of user participation which is unrealistic for many care clients with more complex needs, and alternatives need to be developed. 70% of social care clients in care have some form of dementia - they are confused, and they have other complex needs such as double incontinence, poor eyesight, difficulty walking and so forth. Having these people who use services using technology is largely unrealistic. End of Life Care clients' needs should be considered specifically when modelling care packages with technology for this growing client group.

- **Recommendations**

Adult social care providers are keen to adopt in new technology but take up is low because of external barriers and lack of understanding by commissioners. There is a need to work directly with the social care industry to identify what is actually needed.

However, by circumventing and overcoming the barriers to adoption, and initiating and funding direct business to business engagement for technology applications, the following opportunities for applications have been identified by care providers:

- **Dementia** applications - eg day centre and supported living interested in dementia roaming devices and systems
- **Monitoring conditions** such as double incontinence
- Technology to support **epilepsy**
- Telecare to reduce **management** time, leaving more time to manage
- Technology that improves the quality of care & supports **higher dependency needs**
- Uses to help people **remain in their own homes** and, when moving into care, need technologies which are both **transferable** and have **interoperability** to allow service user's changing needs are met with minimum disruption
- An affordable **paperless process**, with instant internet access to rosters and admin.
- Dispensing medicines through telemedicine technologies.

In addition, there are social and therapeutic benefits to improve the health and wellbeing through stimulation from the use of technologies, such as:

- Wii usage
- Internet shopping
- Broad spectrum 'daylight' lighting and 'mood' lighting
- Non-intrusive tracking
- Use of webcams and video links for communication and social interaction
- Applications requiring broadband.

- **Next Steps - Put the two industries at the heart of future developments**

The clear message is that action is required now. As more adult care providers change their business models to service the needs of private individuals, engagement with public sector agencies becomes less relevant and the urgency to understand policy is diminished. There may be a danger that, if changes are not made in the way the Transformation Agenda is being implemented by Government as described in this report, the influence may shift and the moment may be lost.

Three major opportunities exist to initiate and fund private sector-led developments. These are:

- support the development of the independent social care sector's representative;
- collaboration with Department of Health in the South East, and
- positioning the social care's independent providers and the telecare industry as the lead partners and primary beneficiaries in Technology Strategy Board initiative such as the Assisted Living Innovation Platform.

1. SESCA and its network of care associations should be developed as a proven route to engagement for market, skills and policy developments. This will require infrastructure funding and a Concordat to define the relationships between all interested parties.

2. Collaborate with Department of Health (South East)

Consultation contributions from GOSE[20]/the Department of Health, South East's Ian Bainbridge (Deputy Director for Social Care) identified priority areas to focus initial work:

Joint planning for assistive technologies for Independent Living

- joint planning between local stakeholders in health, social care and housing is often not in place and the potential is not maximised and/or possible funding not identified.

Supporting independent Living for people with Dementia

- There is a need to address the gap between the possible and the actual is great with regards to supporting independent living for People with Dementia. This is an urgent issue for health and council partners to recognise and address with:
  - the recent publication of the National Dementia Strategy,
  - the increased awareness of unmet need, and
  - the responsibilities for delivery of joined up well planned services that are seamless between PCTs and Councils.

3. Private industry to lead on Technology Strategy Board initiatives

Use initiatives such as the Assisted Living Innovation Platform and other Technology Strategy Board schemes to fund and support direct engagement with business. Social care's independent providers and the telecare private sector business should be engaged to address and develop the Assisted Living Innovation Platform.

[20] GOSE = Government office of the South East

SECTION 1 - The adult social care sector in the South East region

1. The Social Care Sector in England

The adult social care sector helps people aged 16 and above who need extra support, or are more vulnerable, to live as independently as possible.

In England the adult social care sector is predominently a private sector industry delivering a public service.

The fact that adult social care is no longer a public sector industry is the result in policy changes and the evolution of the role of local authorities.

This change is recognised by CSCI[21] who state: 'the specific sectoral features of the adult social care market differentiate it from other major public services such as health and education. For example:

- some 91% of care home places in England are delivered by the independent (private and voluntary), rather than the public sector;
- 82% of agencies providing home care are likewise in the independent sector;
- services are delivered through some 24,000 registered providers, of whom only 150 are local councils;
- adult social care is still a sector dominated by small providers. Despite recent consolidation, the top 10 care home providers control less than 25% of the market.'

The **Department of Health** describes the industry at national level as follows:
"The social care workforce in England comprises over 1,000,000 people working in people's own homes, care homes, day care, hospitals, and in the wider community. An estimated 67% of the workforce work for some 25,000 employers in the independent sector. The remaining 33% work in the statutory sector, largely for 150 local councils with personal social services responsibilities."

Of these adult social care providers, the majority are small and the 10 largest providers only own 25% of the private residential market between them.

- Public sector: there is still a small remnant of services that councils provide directly. This equates to 9% of care homes and 17% of domiciliary agencies. Councils also provide nearly 80% of adult placement schemes, although the carers themselves are not local authority employees.
- Private sector: the majority of adult social care providers are private sector. Almost 70% of care homes and over 70% percent of domiciliary agencies are operated by the private sector. Many of these providers sell their services to councils as well as to private individuals.
- Voluntary sector: the voluntary sector is also a key service provider[22]."

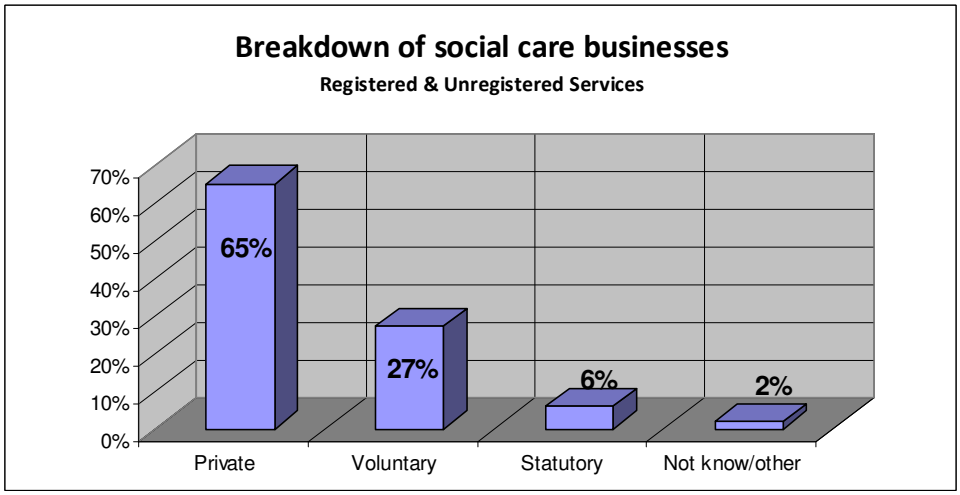
As a result, the onus for delivering services which meet demand effectively in practice falls to independent sector providers. The sector is facing unprecidented growth in free market demand for its services plus pressures from Government and its customers to improve quality and choice, while maintaining affordability and inclusion – a significant challenge for any industry. Yet, in the adult social care sector, Government policy and initiatives to drive quality and to release innovation and efficiency gains among this entrepreneurial business community are too often hampered through the lack of meaninful, direct dialogue and collaboration with the industry's business leaders.

[21] CSCI is the Commission for Social Care Inspection. On 1st April 2009, CSCI will transfer its responsibilities to the new care and health regulator Care Quality Commission (CQC)
[22] Extract from DH website: http://www.dh.gov.uk/en/SocialCare/Aboutthedirectorate/Howsocialcareisdelivered/index.htm

2. The Social Care Sector in the South East region

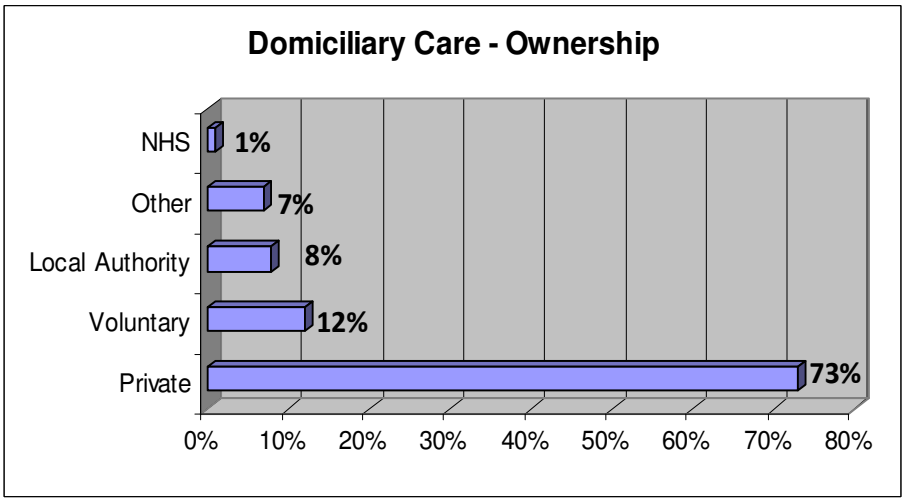
In the South East, 92% of all services are run by the independent sector. As the English region with the largest number of adult social care providers, the South East is home to 4,500 registered services, 76% of which are private sector organisations, plus an additional approximately 1,000 unrequstered services which operate largely in the voluntary sector. Therefore, the region is home to some 5,500 providers; of these, 65% are private businesses[23], and statutory[24] services account for only 6% of provision (see chart below). The sector's annual revenue is £10.16 billion.

The industry employs 147,000 people (equivalent to 113,000 FTE's[25]), which is 3%[26] of the working population of the South East. They work for the 5,500 care providers, of which 4,500 are registered[27] services, and the remainder are unregistered, primarily voluntary sector, services.



An analysis of the region's registered services show that, for those supplying domiciliary care services:

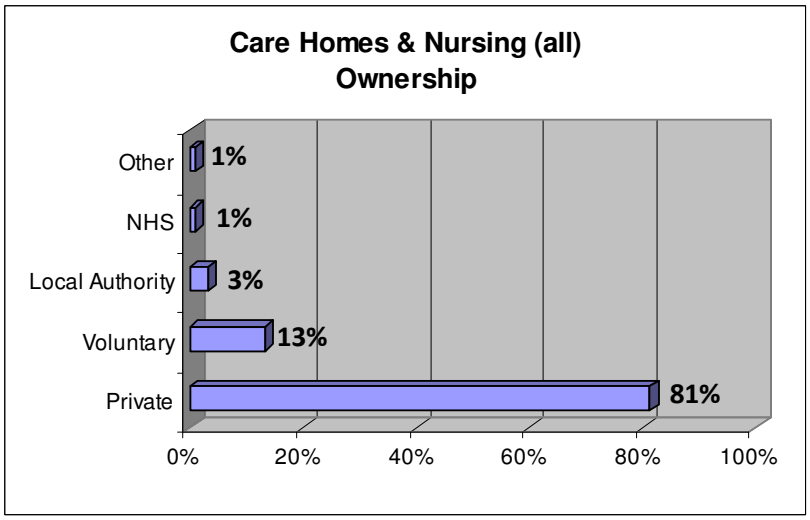
- 13% are run by the statutory sector, and
- 95% operate in the independent sector, with 73% of these providers being privately owned, and, Only 12% run as voluntary organisations.



[23] From CSCI data & NMDS-SC data
[24] Statutory services are a combination of NHS and local authority owned services
[25] FTEs = Full Time Equivalent workers
[26] Based on the region's population figure of 4.7 million in the working age range from the 2006 census
[27] ie Care providers registered with CSCI www.csci.org.uk, the industry's regulatory body. From 1st April 2009, this responsibility will move to the Care Quality Commission (CQC) http://www.cqc.org.uk/

Similarly, care home and nursing services provision is dominated by private businesses, with:

- only 4% owned by the statutory sector, and
- 94% run by the independent sector, of which only 13% are voluntary organisations.



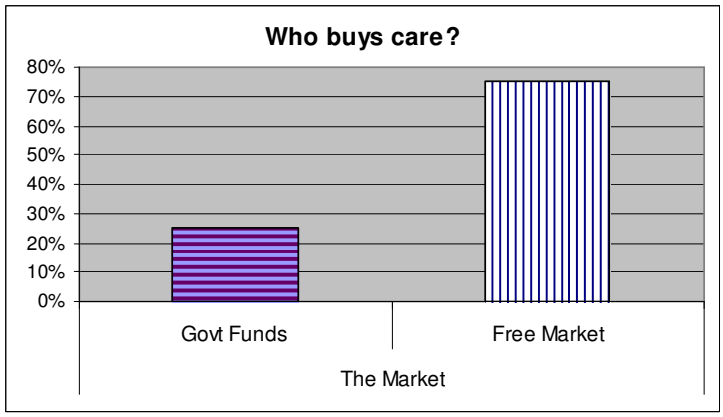
Summary

At both national and regional level, the vast majority of the industry operates in the independent sector – and primarily as private businesses. Today, local authorities are minority suppliers and employers of care services.

3. The Sector's Customers

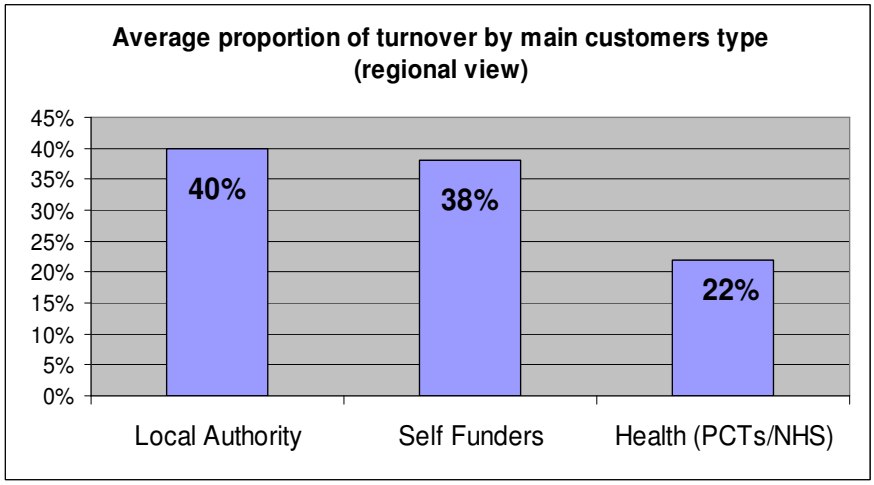
'For too long, adult social care and services for older people has been the poor relation of health and children's services.'[28] The trend in local authority elderly care purchasing over the last ten years has been one of a reducing numbers of residential and nursing home beds, at a time when the demographic profile of older people has been increasing. During this period there has been a growing requirement for more specialist provision to reflect higher dependency levels, and for services which enable more people to remain in the community. The market has become more fragmented with a growing number of providers exiting the market; traditional supply is often no longer seen as fit for purpose in relation to both the dependency levels being placed, and increased service user expectations. This is reflected in higher costs of provision, and an increasing trend in the use of third party top-ups for beds over the local authority declared rates.

[28] Quote from Andy Sawford, Chief Executive of the Local Government Intelligence Unit (LGiU)



The current system is very dependent on private and informal care. Nationally, only 25%[29] of care for older people is local authority funded for eligible seniors with less than £22,250 in assets, and this percentage is dropping year on year as the market grows and public resources diminish in real terms. Where local authority funding is available, co-payment is already a reality. In the year up to March 2006, personal top-ups to local authority care amounted to £1.6 billion. Moreover, 150,000 recipients of domiciliary care and 18,000 recipients of residential care paid a further £4.2 billion from their own resources. However, it is clear that further research is required to properly understand the purchasing profile for care, and the levels to which top-ups are being relied up.

In the South East, the survey of 6% of the registered social care providers shows that, on average, 40% of turnover is generated from local authority income for those providers who do business with adult social services commissioners. Of the remaining 60%, 38% coming from individuals paying privately for care (self-funders) and 22% from NHS income.



4. Market Segment Classifications

The classifications by types of services within the adult social care industry are:

• Assisted Living	• Intermediate care
• Domiciliary/home based care	• Day care
• Extra Care	• Supported living
• Care homes	• Continuing care
• Care home with nursing/ Nursing Home	• Community care
• Respite & short term care	

[29] All Party Parliamentary Local Government Group - Never Too Late for Living. Note – this figure is not in line with CSCI reporting; CSCI claim up to 70% of care is purchased by Government funding. More research is needed in this area as it is complex and it raises a number of important issues.

SECTION 2 - The Telecare sector in the Greater South East region

1. Introduction

Telecare is the use of sensor and information and communications technologies to deliver care and support to people in their own homes to allow them to live as independently as possible.

Improving the management of chronic and long term conditions is a key priority for national health policy. The emergence of telecare over the last few years provides carers with a new care delivery option which helps them manage the risk of maintaining people in the community, allowing earlier identification of changes in the person's condition and enabling more appropriate and timely interventions.

To date, the main focus of telecare has been on (1) home safety and security monitoring and (2) vital signs monitoring within a 'reactive mode' approach, i.e. where an alert triggers a response from an appropriate service. So far the use of telecare has been limited to small scale trials which have been developed from a small selection of standardised devices. In the main these trials have not been fully integrated with the whole health and social care system and have been reactive. To meet future needs, telecare will have to be available on a much larger scale, involve many more sensors and devices capable of being personalised to individual user needs, be predictive (to allow observation of longer term trends and earlier intervention), and be fully integrated with the care system.

> "People constantly look to modern technology to improve their lifestyles. One of the ways in which life could improve for older people is in the harnessing of new technology in new, imaginative and profitable ways."
>
> *The Royal Commission of Long Term Care (1999)*

This section of the report highlights the companies and universities involved in developing and delivering products and services associated with Telecare in the SEEDA regional and the Greater South East. It also addresses briefly the market opportunities and the challenges associated with addressing these.

2. Companies associated with Telecare in the Greater South East region

There are 63 Telecare firms in the region, employing over 3,000 people and with operating revenues over £600 million.

There are 25 small firms, 17 medium size and 9 large firms. 2 other firms are very large with over 300 and 600 employees respectively, and operating revenues at £64 million and £378 million.

	Employees: Numbers in 2007	**Operating revenues / Turnover: £'000 in 2007**	**Profit / (Loss) before tax: £'000 in 2007**	**Total assets: £'000 in 2007**
Min	4	15	(3,424)	0
Max	616	378,613	8,631	191,963
Total	**3,157**	**673,203**	**740**	**388,204**

10 firms have operating revenues over £10 million, which suggests significant levels of activity.

Number of Firms	Operating Revenue
12	< £1 million
13	£1 - £10 million
10	£10 million >

67% of firms fall into the small and medium sized company categories with fewer than 250 employees. Of these, 40% are small, employing fewer than 50 people. Only 11 firms employ more than 250 people.

Category of Firm	Number of Firms
Small	25
Medium-sized	17
Large	9
Very large	2
TOTAL	**63**

21 firms have between 2 and 12 shareholders.

Number of Firms	Number of Shareholders
4	0
28	1
7	2
5	3
3	4
1	5
1	7
1	9
2	11
1	12

2 firms have a complex subsidiary structure – with 14 and 15 subsidiaries respectively. One of these firms is 'Sunrise Senior Living Limited', established in 1997, with 14 subsidiaries, registered in Beaconsfield (Aylesbury) and London, and these subsidiaries operate in various towns in the South East.

Number of Firms	Number of Subsidiaries
40	0
9	1
2	2
1	14
1	15

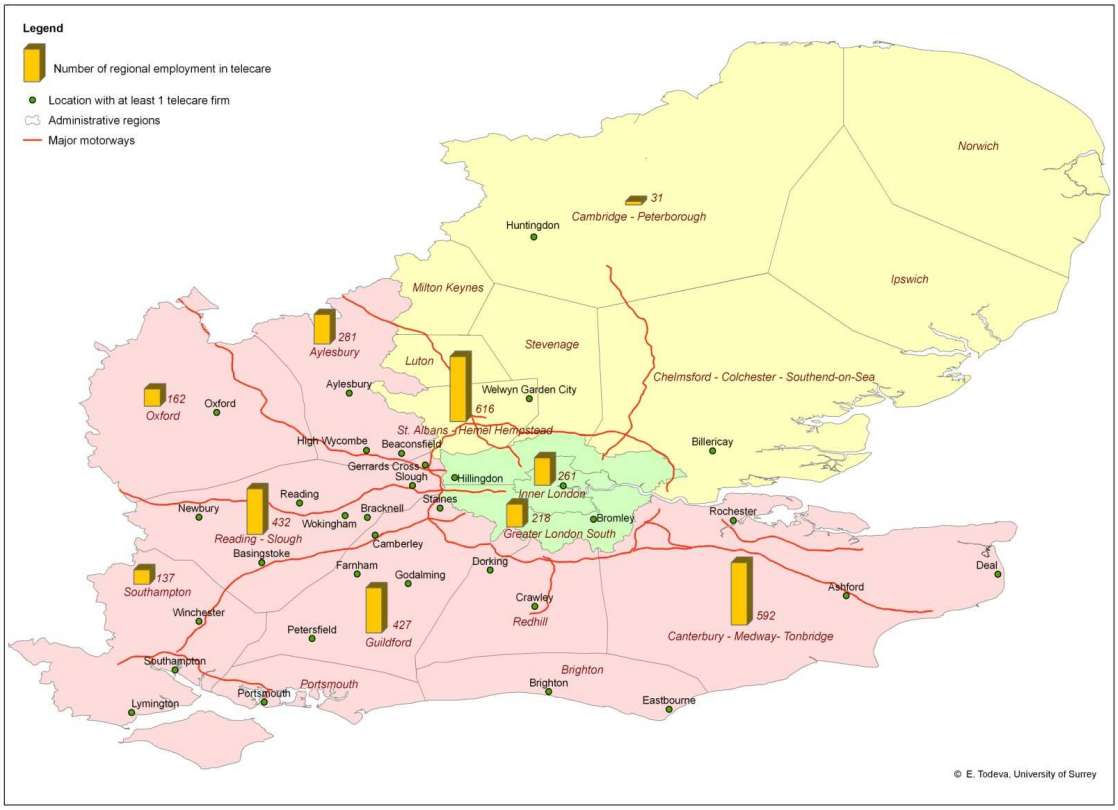
Although there are only 3 Telecare firms in the East of England region, these are mainly large firms which are significant contributors to the overall cluster employment and revenue.

The largest concentration of telecare firms is in Inner London, and Aylesbury (Beaconsfield), followed by Reading-Slough, Canterbury and Guildford.

Location	Number of Firms
Inner London	15
Aylesbury	11
Reading - Slough	11
Canterbury – Medway - Tonbridge	5
Guildford	5
Oxford	3
Southampton	3
Brighton	2
Greater London South	2
Redhill	2
Cambridge - Peterborough	1
Chelmsford - Colchester - Southend-on-Sea	1
Portsmouth	1
St. Albans - Hemel Hempstead	1

The range of expertise within these firms is very wide, covering activities such as manufacture of computers and other information processing and electrical equipment, medical / surgical and orthopaedic appliances, telecommunications, software and hardware consultancy, other computer related activities, education, hospital activities, medical practice, social work with or without accommodation, other services.

The distribution of telecare firms in the Greater South East region is similar to the distribution in other clusters from the health technology sector – multiple locations in the South East region, and high concentration in London and selected towns in the Eastern region.



For a full list of Telecare firms in the Greater South East, please see Appendix IV.

Alongside the core companies involved in telecare, there are many other, often smaller, companies involved in support services.

In the Greater South East region, there are over 9,700 companies involved in the delivery of health and social care and associated support services.[30] The social care sector has been examined elsewhere in this report. However, health (medical) care companies, of which there are approximately 4,900, include clinics, hospitals, ambulance services, eye-care services, osteopaths and chiropractors. There are also 478 dental care companies. Plus, over 1,100 medical care business support companies provide consultancy, management, external support services for primary and secondary care, recruitment and transport.

Health (medical) and social care in the Greater South East is a multi-billion pound industry employing thousands of people and caring for millions. It is an economically and socially vital sector within the region.

3. University Excellence in Telecare in the South East region

Alongside the industry activity in telecare, the South East region boasts several universities with expertise in the subject. The table in Appendix IV highlights most of the significant basic and applied research activities in the regions universities.

4. Markets for Telecare and Challenges to access markets

According to the Technology Strategy Board, the world spends about £2 trillion per year on healthcare and 75% of this relates directly or indirectly to managing chronic diseases. The global market for telecare was worth about £400 million in 2006 and is estimated to exceed £4 billion in 2010.

In the UK there are around 17.5 million adults with chronic disease problems. As a proportion of the national total, in the Greater South East this figure is in excess of 6 million. Each of these adults will at some stage in the future benefit from some form of telecare to monitor and manage their health and care conditions more effectively and efficiently. At one level this could simply involve regular monitoring of blood pressure or blood sugar. More intensive telecare support could involve monitoring many physiological parameters alongside the provision of several safety and location monitors in the house (eg water and Carbon monoxide sensors).

Currently, there is no data available which accurately predict the market for telecare services, but the following incomplete analysis may give some indication of the potential market in the Greater South East for such services.

If we assume that 'minimal' telecare services could be used by 3 million of those 6 million adults, 'moderate' by 2 million and 'intensive' by 1 million, and that only 10% of the potential users take up the service, then the likely annual market for such services could be:

- £1,000 per year for 'minimal' x3 million = £3 billion/10 = £300 million
- £2,000 per year for moderate x 2 million= £4 Billion/10= £400 million
- £4,000 per year for intensive x 1 million= £4 Billion/10= £400 million

Total potential market in the Greater South East region = **£1.1 billion** per annum

[30] Report: Health Technology Cluster in the Greater South East, Todeva and Keskinova, 2008, sponsored by SEHTA

The complexity of delivering a telecare service is shown in Figure 2 (below). A telecare service is part of an integrated service delivering support to people in their chosen 'home' environment. A large number of stakeholders are involved in telecare including the client and their informal carer, the care services, the voluntary sector, and the private sector. Each one is involved at a different stage. A telecare service will only work well if the roles and responsibilities at each stage are understood, appropriate information is passed between stages and telecare is integrated with the other service delivery options which make up the individual's care package.

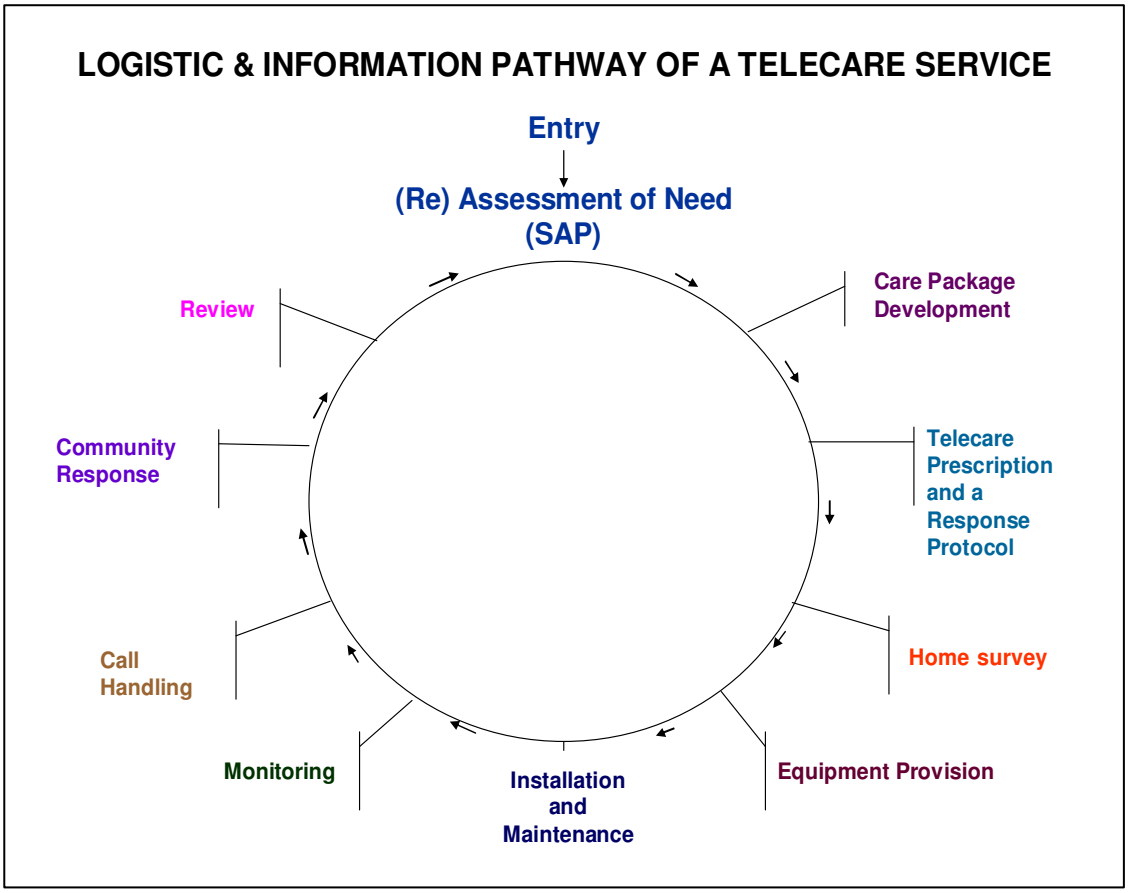


Figure 2

The difficulty in building a business case for telecare is that whilst the benefits of telecare may lie with one stakeholder (often the individual), the costs lie with another. Based on a few short term, limited scope projects it is possible to identify costs and by comparing them with historic costs identify some savings (eg in terms of bed-days). However, it is more likely that the costs are distributed across the whole local health and social care economy, but these more sophisticated models have yet to be developed. If they could be developed they would allow the inclusion of other outcomes into the model such as increased patient confidence, increased self care, prevention, risk reduction and public health improvements, which may be the value of telecare.

The care model where a supplier builds a facility and, through the staff, provides a level of care is an inflexible model. In particular, it does not cater well for an ageing population with increasing expectations and changing needs. Like all employers, the independent care sector has to cope with the problems of the recruitment and retention of staff and with increasing regulation. The option to build more facilities to increase turnover is reduced because of low land availability and high building costs. Even if this were a possibility, it may not be realistic to achieve many economies of scale because one of the major costs of running care facilities is the cost of care staff. Telecare offers an opportunity to the independent care sector (both new entrants and established suppliers) to reduce their cost base and

expand the number of services they offer whilst retaining staff. This business opportunity is not being addressed because there is no organisation that can offer these independent care sector providers an integrated telecare service.

This market failure can be addressed by forming a consortium of companies lead by an integrator on both the supply and demand sides. On the demand side (care provision), SESCA can bring together the potential commissioners of telecare; they can define their needs and then procure for supply. On the supply side, SEHTA can facilitate the creation of consortia of companies to deliver the range of services required by the purchasers.

For telecare suppliers, collaborating with the independent care sector has advantages over the statutory sector:

- the business proposition is more straightforward as the number of stakeholders is reduced;
- the supply chain is easier to construct as the response team is largely in place in the form of the current care staff;
- the barriers to investment are lower than in the statutory sector; and
- the independent sector works at the frontline to deliver care services for the customer and, therefore, is best placed to define needs, to implement technologies and to support research and development for future technologies.

The world's developed countries face problems in delivering care over the next decades, so the development of an effective supply chain in the UK will be able to be applied to an international market.

SECTION 3 – Issues facing the social care sector in the South East region

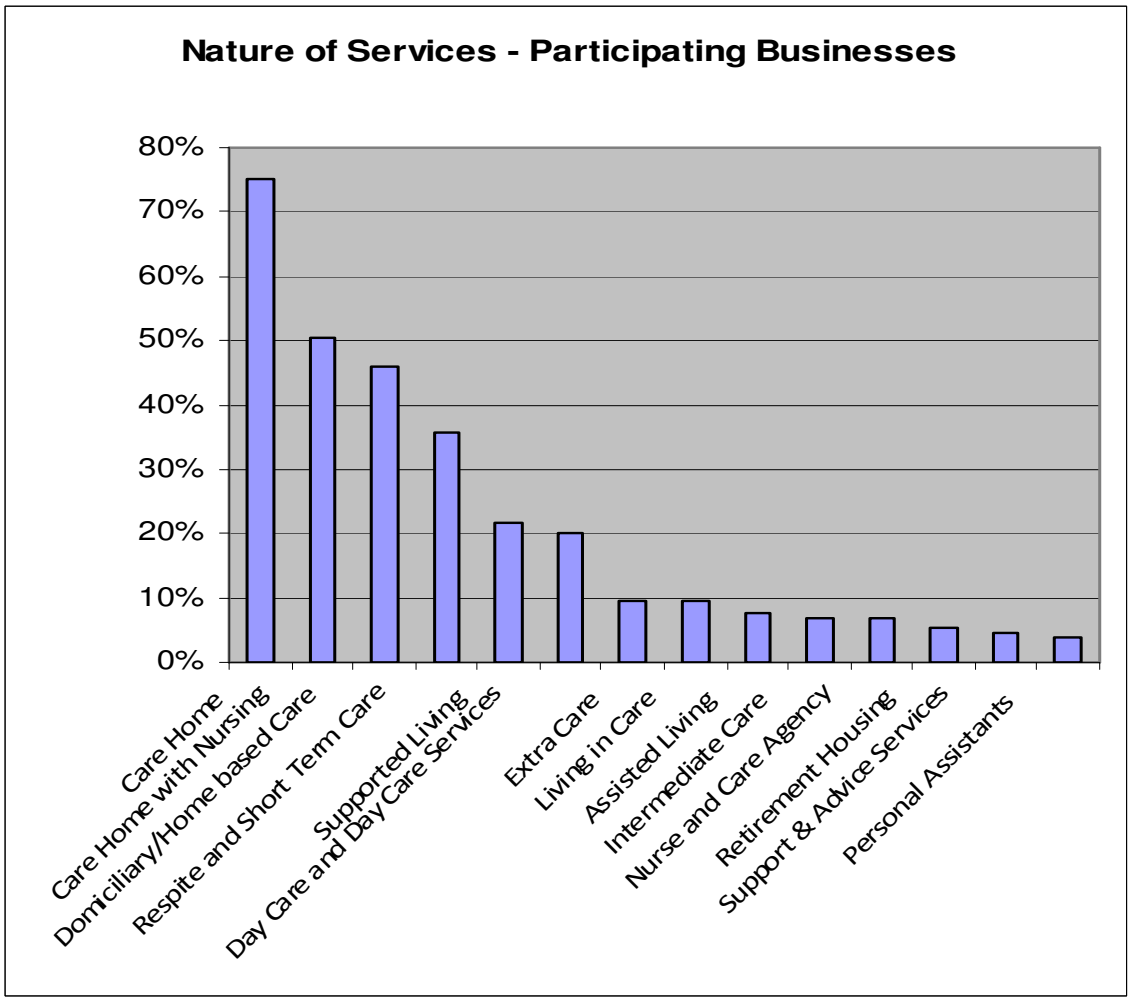
1. The Consultation

SESCA consulted with the independent sector to produce a 'snap shot' of the views of businesses in the South East, and to understand the key issues and opportunities they face. The project does not intend to provide definitive research, although the level and the integrity of responses ensures the data has credibility. The findings are based on a sample of 6% of SME registered services across the region and, as such, it does not claim to be a thorough investigation. The following analysis is based on the 276 responses which the region's care associations received in early January 2009.

2. Participating Businesses

2.1 Profile

To ensure the sample was as representative as possible, the responses were received from SMEs providing the following cross section of services:

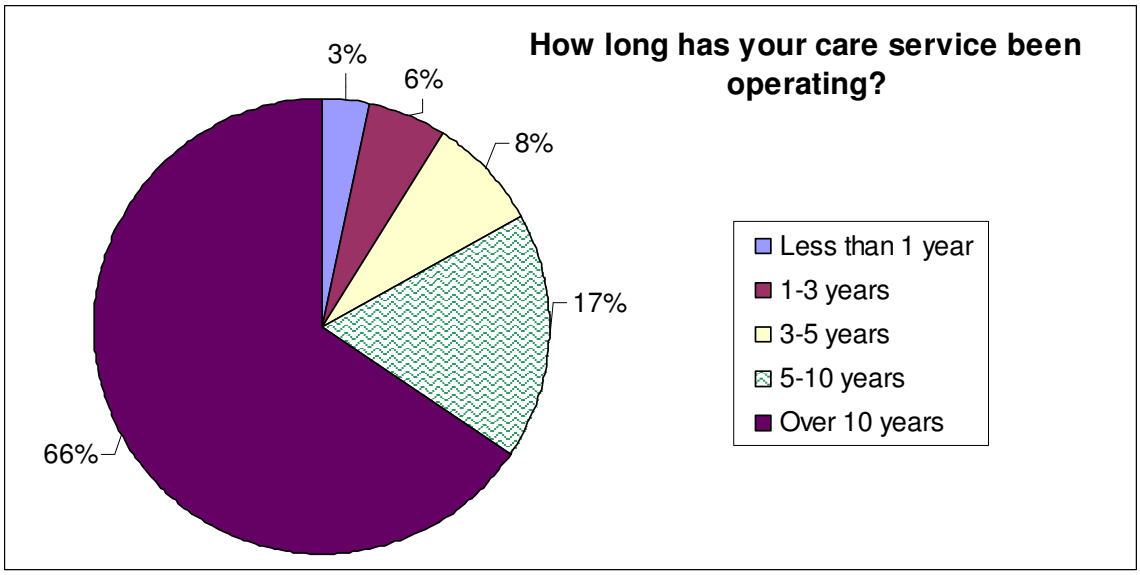


The providers range from those who offer one type of service exclusively, to those who offer multiple services, such as:

- Care home, care home with nursing, respite and extra care (or combinations of these);
- Care home with nursing, intermediate care and day care;
- Intermediate care and extra care;

- Domiciliary care, living in care, personal assistants and supported living (or combinations of these);
- Retirement housing, supported living and support & advice services.

91% of these providers are running a service which has been in business for 3 years or more, with 83% having been operating for more than 5 years and 66% have more than 10 years experience.

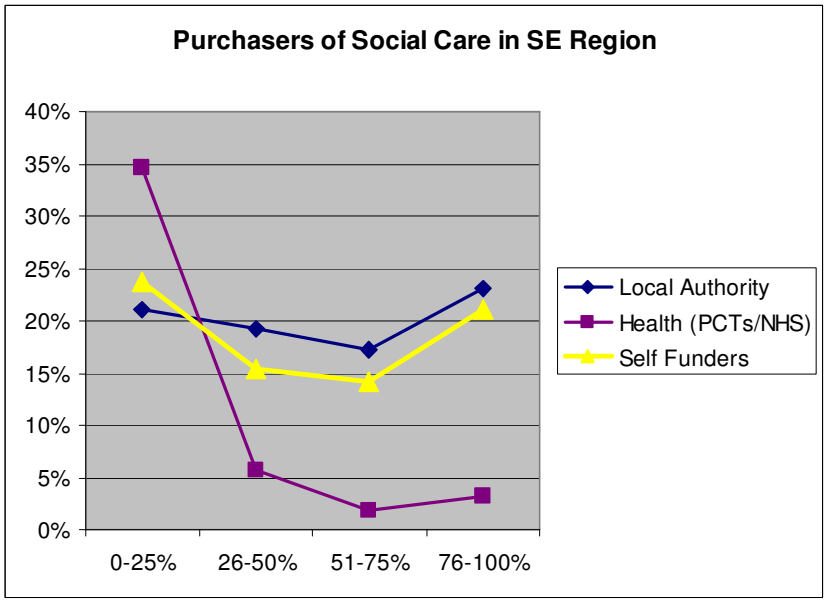


2.2 Customers and Income Profiles

The main customers of adult care services are:

- local authorities (social services departments, by whatever name);
- 'self-funders' (private individuals who fund their own care), and
- health (PCTs, NHS).

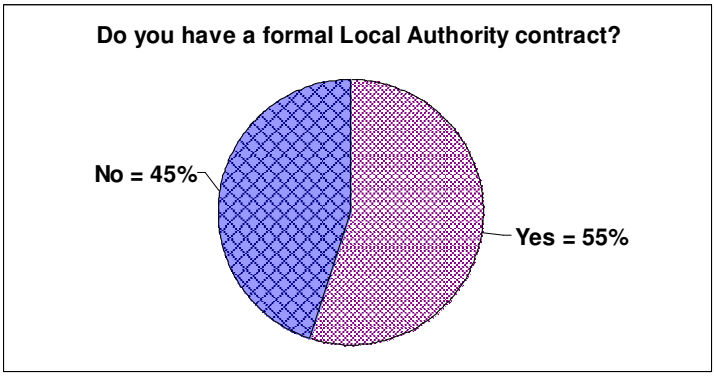
An analysis of the percentage of a care provider's turnover which is generated from each of these customers reveals that there is very little difference between local authority income and that generated from private clients. The chart on the left gives a breakdown of this income profile against the percentage of turnover each purchaser represents. This analysis shows that:



- local authority contracting levels are fairly evenly distributed across the range. However, 23% of businesses still rely on local authority commissioning for between 76 - 100% of their turnover;
- income from self funders is similar to the profile of the turnover levels generated by local authority business.

However, it shows that 24% of providers are generating 25% or less of their business from self-funders and there are a significant number of businesses (21%) who are generating between 76 -100% of their turnover from this market[31].

- commissioning from the health service reflects a higher level of small purchases from a large number of providers (35% of the sample). Higher volume purchasing is low and only 3% of providers rely on 76 - 100% health contracted business.



55% of providers in our sample hold formal 'block' contracts with local authorities. Of the remaining 45% who do not, a significant number do sell some level of their provision to the statutory sector under 'spot' or 'ad hoc' contracting arrangements.

From an image viewpoint, the public's perceptions of care services, particularly those offering residential facilities, is often skewed by the view promoted by local authorities whose perspective on care supply can relies on their commissioning relationship with lower quality providers who remain interested in delivering cost-based services.

2.3 Industry Developments and Growth-related Issues

62% of businesses in our survey confirmed that they were making changes to their services over the next 12 months. These changes were described as follows:

Changing or diversifying services in response to market need - examples include:

- increase privately funded clients
- decreasing local authority beds
- care homes changing from residential to supported living, or from elderly to learning disabilities - care home with nursing
- expanding domiciliary care & supported living, or moving into these areas
- domiciliary care diversifying to offer 'live in' carers, or introducing additional services (eg handyman/gardener/domestic & night sitters)
- Introducing outreach (respite), or specialist provision (eg Aspergers)
- developing palliative care beds for PCT funding
- Offer 'holistic' care, not just physical care
- Improve services (eg enhance social activities & update equipment).

Expansion & Refurbishment – examples include:

- Developing or expanding niche provision (eg dementia / post traumatic / neurological injuries / community physio unit / head injury)
- build new bed unit (nursing care)
- Expand (domiciliary care)
- Expand on other sites (intermediate care)
- Relocate to better or larger premises (supported living – Learning Disabilities)

[31] **NOTE ON THE RESULTS**: It is worth noting that this data is likely to be distorted because the consultation sought to be inclusive across all types of care services. This may have led to a bias towards local authority-purchased care. For example, most respite and intermediate care provision is in the quasi-state sector (eg former local authority homes which were sold to the independent sector with existing, long-term local authority 'block' contracts at rates higher than the standard local authority 'spot' contracted rates). This type of anomaly may have produced results with little apparent difference between local authority and private rates which is not the case in a number of areas. A fuller analysis of these effects is outside the scope of this project.

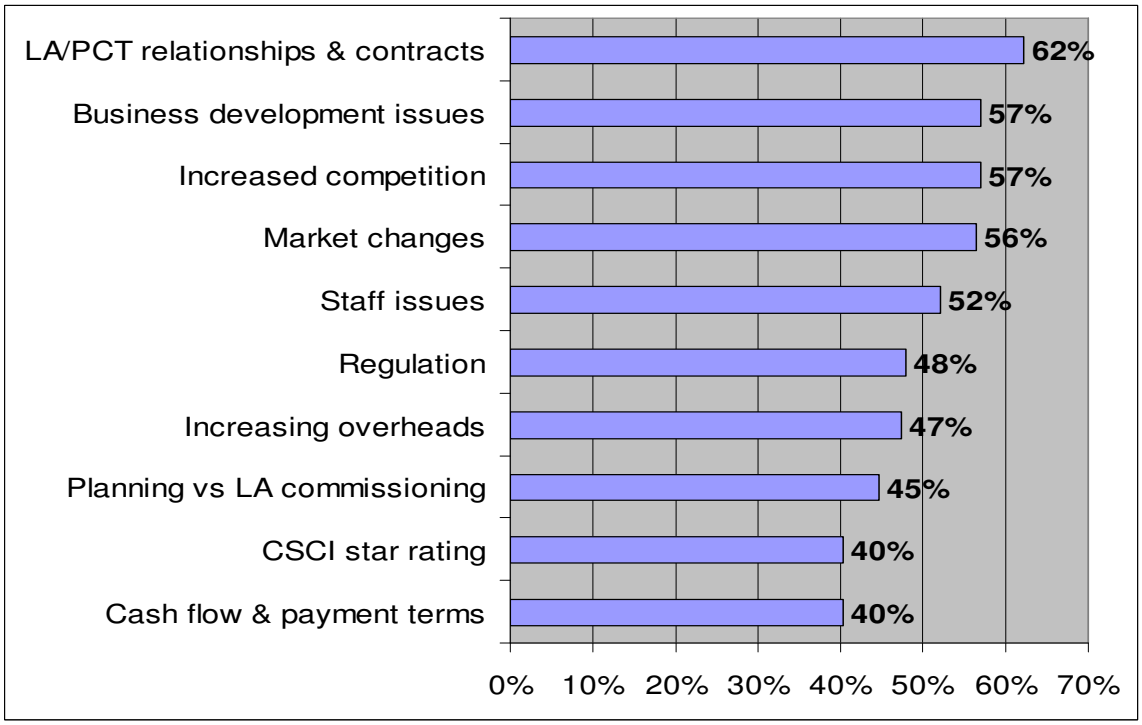
- Develop supported living service
- Diversify into short term & extra care - older people
- Upgrading facilities / refurbishment / new proprietor (specialist staff)
- Extension with more beds (care homes / nursing homes / intermediate care / respite)
- Looking for new site (retirement housing / care home)
- Moving to new, larger premises (care home & respite)
- Develop own training function and grow Self Directed Support Service

Cost Management – examples include:

- Day care relocating to reduce costs
- May hand over to a property management company
- Increase use of IT.

2.4 Key issues affecting business performance

The survey asked providers what they saw as the main issues facing their businesses over the next 2 years. These issues relate to the ability of providers to maximise their efficiency and to manage administrative and management costs effectively, thus enabling them to focus resources on quality and innovation. The results are shown in the chart below:



From this analysis, the top 5 issues are:

- Relationships with public sector commissioners (ie local authorities and PCTs) (including policy changes, contracting issues such as funding levels, general lack of meaningful dialogue)
- Business Development: (particularly the lack of specialist expertise to develop the business and to improve efficiency/quality/ICT/Carbon footprint or source care technologies / Investment funding)
- Increased competition
- Market changes: (including issues relating to changes in the customer base, ability to fill beds & responding to more complex client needs)
- Staff issues: (including turnover levels, salaries, recruitment, training, CRB, immigration changes).

62% of providers identified that their relationships with public sector commissioners was an issue to their business. In addition, the survey identified that 45% of providers found that the way local authorities handled their commissioning processes had a detrimental impact on their ability to prepare and implement business plans. Taken together, this shows that issues relating to public sector commissioning, policy developments are the major issue for the industry with the strongest message relating to the level of funding not matching the level of need or the ever-increasing demands for quality improvements and flexibilities.

The next 3 big issues relate to business and, more particularly, to understanding external market developments and how to respond to these to build capacity and competitiveness. The fifth issue relates to staff, and 52% of providers recognise the high cost of recruitment, retention and staff development in an industry which runs on low wages and large numbers of non-indigenous workers.

In sixth place, 48% of providers identified regulation as an inhibiter (primarily the amount of regulation, the rate of change, the inconsistent interpretation and implementation, the lack of timely and meaningful consultation, and the perception that regulation is based on theoretical data rather than on the experiences of deliverers).

2.5 Solutions to the key issues affecting business performance

When asked if solutions existed to these issues, and, if so, what difficulties existed in implementing them, providers' comments included:

A more open, equitable and realistic dialogue about policy, commissioning and regulation:

- The main problem is lack of funding and investment from local authority/government. Regulation and legislation have increased, the staff and management role is much more skilled yet the equivalent amount of support, either financial or through training, is not available. Local authority fees fail to meet the real cost of the care. The cost of providing this care has risen dramatically. We are starting to set out our fees and require that the local authority meet these for new clients, if not then we will only consider clients that are self funding.

Respond to the market:

- Within 5 years we will need to have developed more small community homes and look at changing our 14-bed site into an assessment and treatment centre or maybe day provision centre;
- Be more competitive with local competitors, more vigilant with cash flow, retain present system of recruitment (from abroad) provided Immigration does not restrict regulation intake further, provide training for staff to be more efficient in IT;
- Continuous development of the service towards a higher quality/more person centred delivery approach. Reduce bureaucracy and duplication of systems. Introduce more user friendly, ergonomic systems & technology;
- The main difficulty is the underfunding which heavily impacts on staffing resources allocation to direct contact and staff development.

While there is no suggestion that the sector disputes the need for both technical regulation and economic regulation (through Government policy), there is a recognition that the relationship between regulators, policy-makers and independent providers needs to undergo a step change to become fully collaborative.

In other industries, economic regulation is usually brought in where there is a monopoly to prevent exploitation and high profits to the detriment of public service obligations. This has been the case for other industries which, like social care, have moved from public to private sector ownership, such as

utilities, trains and telecoms. However, this is usually because there is one big buyer, but this is not the case in care as the market should be sufficiently dynamic to ensure competitiveness.

Unlike other industries which have made a rapid and well-publicised transition from public to private owners (through share issues, for example), the social care sector's transition into private ownership has gone largely unnoticed and indeed unrecognised by many. As a result, the public sector still has an undue influence over how the sector operates. For example, the Department of Health relies on the views of local authorities to feed back on policy, while the independent sector has limited levels of engagement in the policy-making process, yet it works directly with people who use services and their carers to deliver the vast majority of care services.

Therefore, the issues raised in relation to private vs public sector relationships is about more than just pricing and levels of service – it is about how a private sector industry can be enabled to drive innovation, quality improvements and market responsiveness with the assistance of Government policies which are drawn from the industry's actual, contemporary experiences, and the needs of those it serves.

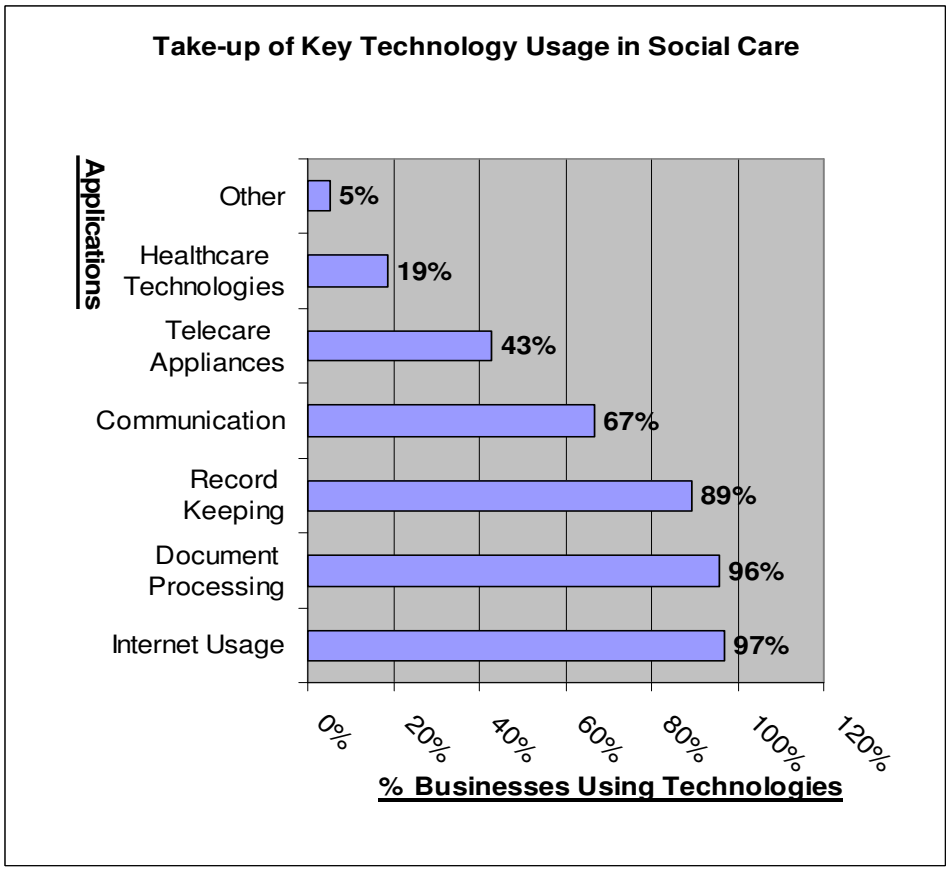
Reposition demand-led skills and staff development initiatives to be private / independent sector-led:

- more interactive relationships with training providers and funders so that employers can better define the training their staff require, particularly with the changing needs of service users;
- more training to meet mandatory or specialist needs (with funding);
- access to funded English language training for non-EU employees as this is essential skill in a service industry such as care;
- the skills and staff development needs of the be run by care providers. We have many groups which are set up to share best practice and to identify issues and this is where training requirements should be sourced;
- our care association provided an excellent skills and business support service recently but the funding ended. This was an excellent model and it should be reinstated as it made a real difference to my service (it was called South East Care Advice Service – SECAS);
- we need 'higher level' business advice and support, including professional advice on technology;
- skills required for using technologies should be fully integrated into all social care roles and competency frameworks. At the moment, there is no sign of Skills for Care doing this work.

The main agency charged with articulating the sector's skills needs is Skills for Care, the Sector Skills Council (SSC) for adult social care. However, this organisation is still understood to be a public sector SSC. As a result, it is run on public sector principles, and it is perceived as a 'top down' delivery agent for the Department of Health. This need to change immediately and, through the Sector Skills Council relicensing process, Skills for Care needs to better reflect and engage with its constituency.

2.6 The use of technology in the adult social care sector

Over 95% of providers in our sample have internet access and computerise their document processing. At 89%, the number relying on technology for record keeping is slightly lower, with a number of providers expressing their concern about the reliability and flexibility of access of computer-based records. In addition, electronic records can be perceived as inappropriate by some CSCI inspectors. However, despite the high levels of internet access, only 67% use electronic communications tools such as e-mail.



However, when it comes to the adoption of care-specific technologies, the survey found that, where applications are in use, they tend to be basic technologies. For telecare appliances, it tended to be simple appliances such as pill dispensers, movement sensors, community alarms and not what the Telecare industry would understand as 'telecare'. With healthcare technologies, in the main the devices are used to monitor conditions/diseases, blood pressure, dementia roaming systems.

When providers were asked about their views on care-specific technologies, the responses revealed:

Discouragement or barriers to direct adoption:

- CSCI discouragement, for example:
  - providers requested not to adopt healthcare technologies as all equipment to be supplied by doctor or social services
  - telecare use deemed to increase the "risk" as part of risk assessment.
- local authorities providing disincentives the independent sector by, for example:
  - restricting access to demonstrators and other technologies purchased through public funds but installed in statutory services or local authority premises;
  - suggesting that telecare technologies should be as part of contract management; for example, domiciliary care to be purchased in line with the logged contact time, thus reducing the value of the contract and disregarding the opportunity costs of this type of care (eg travel time etc.).
  - in some statutory services, management's view is that local authorities assess needs and supply telecare/healthcare equipment – 'our carers use what is provided'. This can discourage the collection and use of feedback from the service user and carer's experiences of using the device.

Issues to be addressed with appropriate advice:

- Not clear about what is available for general use - for example, current uses include (i) computers (including use for online shopping etc), (ii) Wii for fitness and entertainment, (iii) webcams for

communications, but some applications need to be adapted for the less able (eg clearer displays for the visually challenged).
- Considering checkit system (eg www.careblox.com) but would like to get feedback from users
- Domiciliary care: concerns that telecare may replace face to face, & technology cause service user anxiety
- Looked at telecare but not seen anything suitable.

Positive experiences of applications:
- Call bell system and alarms, movement sensors, snooze alarm & pressure pads useful
- Valued use of healthcare monitors (eg diabetes, blood pressure)
- Technology tracks carers (domiciliary care)
- Enables greater comfort for service users
- Improved security (alarms) - peace of mind for users and families
- Met CSCI requirements (purchases made to meet specific client needs)
- When used with risk assessment, they have improved business efficiency and health & safety
- Met CSCI requirements as the purchases were made to meet specific client needs. (This comment points to the inconsistencies which arise from CSCI's inspectors with their own views of the value of telecare.)

Opportunities for applications plus issues to be addressed:
- **Dementia** applications - eg day centre and supported living interested in dementia roaming devices and systems
- **Monitoring conditions** such as double incontinence
- Technology to support **epilepsy** would be useful
- Telecare could reduce **management** time, leaving more time to manage
- Technology that improves the quality of care & supports **higher dependency needs**
- Uses to help people **remain in their own homes** and, when moving into care, need technologies which are both **transferable** and have **interoperability** to allow service user's changing needs are met with minimum disruption
- An affordable **paperless process**, with instant internet access to rosters and admin.

In addition, there are social and therapeutic benefits to improve the health and wellbeing through stimulation from the use of technologies, such as:
- Wii usage
- Broad spectrum 'daylight' lighting and 'mood' lighting
- Non-intrusive tracking
- Use of video links for communication and social interaction
- Applications requiring broadband.

2.7 A Recognition of the Value of Technology

The consultation shows that there is an overwhelming recognition that technology is valuable, with 92% of respondents agreeing it had improved performance, and there is a strong desire to find out more about appropriate technologies, with 78% of respondents stating that they would like advice on appropriate technologies.

2.8 Next Steps - Public Sector Engagement and Initiatives

The clear message is that action is required now. As more adult care providers change their business models to service the needs of private individuals, engagement with public sector agencies becomes less relevant and the urgency to understand policy is diminished. There may be a danger that, if changes are not made in the way the Transformation Agenda is being implemented by Government as described in this report, the influence may shift and the moment may be lost.

Three major opportunities exist to initiate and fund private sector-led developments. These are:

- support the development of the independent social care sector's representative;
- collaboration with Department of Health in the South East, and
- positioning the social care's independent providers and the telecare industry as the lead partners and primary beneficiaries in Technology Strategy Board initiative such as the Assisted Living Innovation Platform.

1. SESCA and its network of care associations should be developed as a proven route to engagement for market, skills and policy developments. This will require infrastructure funding and a Concordat to define the relationships between all interested parties.

2. Collaborate with Department of Health (South East)

Consultation contributions from GOSE[32]/the Department of Health, South East's Ian Bainbridge (Deputy Director for Social Care) identified priority areas to focus initial work:

Joint planning for assistive technologies for Independent Living

joint planning between local stakeholders in health, social care and housing is often not in place and the potential is not maximised and/or possible funding not identified.

Supporting independent Living for people with Dementia

There is a need to address the gap between the possible and the actual is great with regards to supporting independent living for People with Dementia. This is an urgent issue for health and council partners to recognise and address with:

- the recent publication of the National Dementia Strategy,
- the increased awareness of unmet need, and
- the responsibilities for delivery of joined up well planned services that are seamless between PCTs and Councils.

Our demographic challenge and the need for efficiency also underlines this important agenda.

3. Use initiatives such as the Assisted Living Innovation Platform and other Technology Strategy Board schemes to fund and support direct engagement with business

Social care's independent providers and the telecare private sector business should be engaged to address and develop the Assisted Living Innovation Platform. The first priorities for this initiative provide an excellent fit with this, as they are:

- Developing a large scale future technology test initiative
- Business modelling
- User Centred Design
- Short term R&D, (both single company SME, and collaborative) in:
  - End to end (E2E) systems modelling,
  - The home hub – home based intelligent processing including aspects such as data mining, privacy and trust,
  - Wide area (Primary Care Trust/Local Authority – national) data collection and event management,
  - Value added services for well being, lifestyle and health management – the patient/ care portal.

Further short term topics developed from the consultation process include:

- "Anytime, anywhere" integrated access to all present and future services, including a variety of mobile access and location technologies.

[32] GOSE = Government office of the South East

Longer term R&D included:

- Complex systems modelling
- “Anytime, anywhere” access in heterogeneous communications environments, software radio and reconfigurable devices, possibly linked to:
- Body wearable and implantable body sensor networks. Low cost, low power (scavenging), and miniaturised devices, intelligent agents. Home diagnostics.
- Long term social studies.

SECTION 4 – Best practice collaboration between public and independent sectors in adult social care

HM Government's Policy:
The case for change – Why England needs a new care and support system

"seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated"

It states:

- "The existing care and support system is not sustainable, because of the impact of changing demographics and expectations in our society. We need to address these challenges now, before their effects are felt on the system and impact on people's lives.
- A radical rethink of the care and support system is needed to address these challenges".
- This drive for change "is unique in establishing a collaborative approach between central and local Government, the sector's professional leadership, providers and the regulator."

Now is the time to bring the independent sector to the top table as equal partners to define and implement change – it won't happen without their collaboration.

1. Introduction

This report has established that, in the South East, 92% of suppliers of adult social care services are independent providers, with 65% of these operating as private businesses and 27% as voluntary organisations. The region's customer base is made up of three main client groups, namely local authorities, self funders (ie private individuals and their families), and the NHS. The initial benchmarking in this report indicates that there is virtual parity of spend between local authorities and self-funders with each group purchasing approximately 40% of provision, and the NHS purchasing approximately 20% of health-related services.

At the political level, the Department of Health shapes the delivery of adult social care services through leadership, policy and guidance. Local councils with social services responsibilities, and in conjunction with their partners, are responsible for identifying the needs of their local population, and commissioning services to meet them. In order to do this, councils work through a number of partnerships and frameworks. The key responsibility for adult social services rests with the Director of Adult Social Services, which is a statutory post in local authorities with social services responsibilities (*extract*: DH website)[33].

Therefore, it is clearly essential for public and independent sector organisations to have an open and interdependent relationship based on trust and mutual respect. Where this exists, these 'partnerships' foster collaborative decision-making which capitalise on both sectors' expertise and ensure the implementation of policies which are beneficial to people who use services as well as to the industry they rely upon.

In the South East, the independent sector has established a network of local care associations to promote and support their interests. As SESCA[34]'s board is elected by these local care associations, the

[33] Extract from DH website - http://www.dh.gov.uk/en/SocialCare/Aboutthedirectorate/DH_080186
[34] SESCA – The South East Social Care Alliance

links between local and regional representatives – and the care provider communities they service - is robust and transparent.

This section of the report reviews the effectiveness of relationships between public and independent sector representatives, and identifies improvement opportunities based on best practice models.

2. SESCA's Community

Through the region's care associations, SESCA represent a constituency of independent sector providers drawn from a cross section of service types. The associations' members deliver the following services:

Care Services	Surrey	MKOB[35]	Berks	Kent & Medway	East Sussex	West Sussex	Hants / IoW[36]
Domiciliary/home based Care	X	X	X	X	X	X	X
Care Homes	X	X	X	X	X	X	X
Care Homes with Nursing	X	X	X	X	X	X	X
Respite & short term Care	X	X	X	X	X	X	X
Day Care & Day Services	X	X	X		X	X	
Support & advice services	X	X	X			X	
Assisted Living	X	X	X			X	
Extra Care	X	X		X		X	
Supported Living	X	X	X	X		X	
Nurse & care agency	X		X				
Personal assistants	X			X			
Intermediate care	X	X		X		X	
Living in care	X	X				X	

3. Care Association Forums

The associations communicate with local providers in a variety of ways, including through regular face to face discussion. These forums tend to be issue-focused to ensure relevance to participating providers. The main meetings and events break down as follows:

Forums/ Network groups	Surrey	MKOB	Berks	Kent & Medway	East Sussex	West Sussex	Hants / IoW
Training / Development	X	X	X	X	X	X	X
Conferences	X	X	X	X	X	X	X
Older People	X	X	X		X	X	X
Domiciliary/home based Care	X		X	X	X	X	X
Learning Disabilities	X		X	X	X	X	
Mental Health	X+		X		X	X	
Registered Managers	X+	X	X			X	
Provider/Owners' Network	X		X			X	

[35] MKOB = Milton Keynes, Oxfordshire & Buckinghamshire
[36] IoW = Isle of Wight

Forums/ Network groups	Surrey	MKOB	Berks	Kent & Medway	East Sussex	West Sussex	Hants / IoW
Nurse & care agency	X+						
Day Care	X+						
Young Physically Disabled	X+						
Registered Nurses	X+						
Marketing Forum				X			
Locality Groups				X			

+ indicates as part of a wider group, occasionally including nurses for special events.

In 80% of cases, local authority representatives attend these meetings to fulfil the following types of roles:

- to advise on policy, commissioning, business & marketing developments and to present on specific topics (eg safeguarding, personalisation and forward plans);
- to note and take action on issues;
- as providers.

Where local authorities are not formal members of a group, they attend by invitation to cover specific topics or they take a standing agenda item (eg procurement or transformation teams).

4. Local Authority Forums

All associations attend local authority meetings where these forums are available and they are full members of relevant groups. Some forums are also attended by healthcare representatives such as PCTs, and others, as relevant.

These meetings are used for information exchange, consultation, and decision-making and the respective groups focus on key topics, for example:

- Training and contracts liaison group
- Safeguarding adults strategy group
- Housing forum
- TSI (Training Strategy Initiative) partnership group
- Domiciliary care liaison group
- Older people's strategy group
- Mental health forum
- Learning Disabilities workforce planning group
- Primary Care Trust (PCT) - Practice Development Forum
- Reference group for transformation/self directed support
- Workforce strategy groups (including those led by Skills for Care[37])
- Policy development & drafting policy documents
- Consultation on new fairer contracting arrangements
- Fee negotiations & cost pressures
- Infrastructure
- Telecare/assistive technology groups
- Mental capacity act
- Project monitoring / evaluation.

[37] Skills for Care is the Sector Skills Council (SSC) representing the interests of adult social care employers in the skills and workforce development arena. They are part of the federated SSC - Skills for Care & Development which represents social care, children and young people's workforces in the UK.

For care associations, the value of these meetings is mixed across the region. Some local authorities provide timely opportunities for consultation and dissemination on all issues which have potential impact on the independent sector. In these cases, the local association is part of the decision-making process, relationships are based on trust and mutual respect and both parties invest resources in formal and informal meetings and dialogues. However, in other parts of the region, this is not the case.

5. Opportunities for Improvement

HM Government's 'A case for change' aspires to be unique in establishing a collaborative approach between central and local Government, the sector's professional leadership, providers and the regulator. This makes implementing changes to improve relationships between independent sector and statutory sector representatives both timely and politically astute. Change will benefit all parties, and measurable improvements are needed to address issues such as:

Establish equal, open and realistic dialogue between public sector and independent providers about commissioning and regulation – ie *consistent, genuine partnerships working*:

- issues relating policy developments and to public sector commissioning are *the* major issue for the industry. The strongest message relates to the level of funding not matching the level of need or the ever-increasing demands for quality improvements and flexibilities.
- 62% of providers identified that their relationships with public sector commissioners was the main issue effecting their business performance, and
- 45% of providers found that the way local authorities handled their commissioning processes had a detrimental impact on their ability to prepare and implement business plans.

Ensure there are sufficient opportunities for consultation and information exchange, and that these are provided early enough to accommodate changes to drafting, to foster meaningful dialogue and to enable collaborative decision-making;

Make these meetings decision-making forums by ensuring that local authority representatives in attendance are senior enough to make commitments on behalf of the authority. Where this happens, the relationship is dynamic and beneficial to all parties. However, where more junior staff are fielded, decisions are taken away and made outside the meetings, leading to a lack of transparency and accountability, and an inevitable erosion in the perceived value of these meetings which can undermine relationships;

Establish greater consistency, collaboration and joint activities across the local authority network to enable the independent sector to engage in a more cost and time-effective way. 5 out of the 6 sub-regions have more than one authority. Where there is little or no collaboration, care associations and independent sector representatives have to attend multiple meetings and deal with variations in procurement and commissioning practices, all of which adds cost, bureaucracy and inefficiency into the system, and undermines the relationship between the two parties;

Ensure equality across interested parties. Currently, an association representative may be a minority voice in a meeting with a large number of representatives from a sub-region's local authorities and PCTs, for example.

Consult with providers to build collaboration and shared values for quality improvements.

- 48% of providers identified regulation as an inhibiter, with issues relating to:
  - the amount of regulation, the rate of change, the inconsistent interpretation and implementation, the lack of timely and meaningful consultation, and the perception that regulation is based on theoretical data rather than on the experiences of those delivering services on the ground.

SECTION 5 - A Strategic Framework for benchmarking the adult social care sector in the South East region

A key part of this project's deliverables is to establish a strategic benchmarking framework using recognised data sources, from which change can be measured. The Commission for Social Care Inspection (CSCI) maintains data on adult registered services so we know the South East region hosts 4,429[38] registered adult services with 92% of them in the independent sector. Together they offer more than 80,000 beds for nursing and care homes and 855 domiciliary care agencies provide carers who support service users at home. In addition, there are many unregistered services about which much less is known[39]. Examples include adult placement schemes, day care, and personal assistants as well as informal carers.

The Department of Health commissioned Skills for Care (SfC) – the Sector Skills Council for the social care sector - to develop a National Minimum Data Set for Social Care (NMDS-SC) which captures data on establishments (registered and unregistered) and individual workers. By the end of 2008 more than 3,000 employers and more than 29,000 staff had submitted data. Given the estimated 113,000[40] FTEs[41] employed just in registered services in the South East, this represents a 25% sample which forms the basis of this benchmarking framework.

These two sources together provide a unique insight into the sector giving detail of sub-sectors including size, geographic distribution, workforce profile including FTE's BAME[42] data. Also, the business profile including women entrepreneurs, disability, skills achievement, earnings and staff turnover rates (See Appendix III).

Commentary
The tables in Appendix III show the breakdown of registered service provision across the South East. The region is sub divided into six localities which are co-terminus with the sub-regions recognised by SfC, SEEDA, the Learning and Skills Council and others. In total 19 local authority areas are represented.

The data shows some significant differences in the pattern of provision. For example, when examining the ratio of care homes to nursing homes, MKOB[43] hosts 2:3 care homes for every nursing home whilst the figure for Kent is almost three times that at 6:6[44]. Indeed, 30% (221) of all nursing homes in the region are located in Sussex. This variance is significant when interpreting the economics of running a service. The mean average number of beds per nursing home is almost three times that of a care home - 45:8 and 16:6 respectively. This implies significant economies of scale for nursing homes. The bed ratio for care homes is significantly skewed by the Learning Disability (LD) sector which averages 8:2 beds per care home[45] across the region. This provides some insight into why unit costs in this type of service are at the higher end of the spectrum.

The degree to which the voluntary sector is engaged is another variance worthy of note. Across the region almost 13% of nursing homes are in the voluntary sector but this varies from 3.7% in Kent and

[38] Source: CSCI website January 2009
[39] Informed estimates state that there are approximately 900 to 1,000 unregistered services in the South East region
[40] Source: National Minimum Data Set – Social Care (NMDS-SC), November 2007
[41] FTEs = Full Time Equivalent workers
[42] BAME – Black Asian Minority Ethnic
[43] MKOB – Milton Keynes, Oxfordshire and Buckinghamshire
[44] Regional average 3:9
[45] 1,379 services providing 11,288 beds

Medway to 17% in MKOB. It is a similar picture for care homes where ownership varies between 12% in Sussex and 48% in MKOB[46].

The distribution of services mapped here is influenced by historical factors, including, property prices, demographics and social policy locally determined through commissioning strategies.

Each locality is mapped identically to allow for comparison. The focus is on the three main categories of registered service:

- nursing homes,
- care homes, and
- domiciliary care agencies.

The first two are further sub-divided into the five major types of service namely:

- Older People (OP)
- Dementia (DE)
- Physical Disability (PD)
- Learning Disability (LD), and
- Mental Health (MH).

There are other types of service which are not included such as Alcohol Dependence, Drug Dependence and Sensory Impairment but the numbers here are very small.

The NMDS-SC is a voluntary scheme and 61% of registered establishments (2681) in the South East had submitted data by December 2008 although participation rates vary from 56% in Kent and Medway to 70% in MKOB. Regional workforce data was available for the same period on 847 managers in registered services, 3,028 senior care workers and 21,667 care workers.

However, NMDS-SC data should be interpreted with caution. Participants are self selecting and the number either failing to answer individual questions or answering 'unknown' is high. For example, data on 49 % of care workers in Berkshire, on the question of disability was either 'unknown' or not answered which could indicate a high degree of underreporting. A similar picture exists with the ethnicity question where data on up to 45% of care workers (MKOB) is 'unknown'.

BAME data does indicate some regional differences. For example, Surrey shows the smallest percentage of senior care workers described as 'white'[47] (45%) against a regional average of 65% and nationally 72%. Surrey also shows more than double the regional average of Asian (including Asian British) senior care workers at 13% and likewise for black (including black British) at 13%.

More than 75% of the workforce is female and it is interesting to note that gender remains more or less constant with seniority. 76% of managers are female as are 80% of senior care workers and 79% of care workers in the region.

The number of people with a disability is very low (around 1%). Questions about the workforce are normally answered by managers or administrators and the high levels of 'unknowns' recorded could reflect a lack of specific knowledge about their workers.

[46] The regional average is 19.98%
[47] White 'other' is a category of data collected but unfortunately was not reported on in this data run

Very few staff are under 20 years of age. Only 2% of care workers fall into this category and no managers or senior staff do. This could indicate that initiatives to engage school leavers are having limited impact. Most workers fall into the 35-54 age bracket (60% of managers; 47% of senior care workers and 41% of care workers) and the age profile generally in the South East mirrors the national picture.

Respondents were often not keen to disclose information about wages. This may partly be due to the need to update the wages on line for each individual worker without the ability to report a percentage increase across the board. The median hourly wage shown for managers in the south east is based on very few responses whilst responses for care workers is much higher although still only around 50%. It is interesting to note that higher staff turnover rates appear to correspond with lower wage rates for care workers, although the data is not yet robust enough to draw definitive conclusions.

Recommendations for Future Data Analysis

It is still early days for this workforce data and we are restricted to using what has been published. In a sense, Skills for Care have produced a wide range of data which we are just starting to understand. One of the outcomes from this benchmarking exercise is the ability to define the measures we want and to request this in a standard format for the future. Thus, benchmarking is set to become more refined. It would be helpful if in future all data were made available by sub region and, for registered services, by registration type (nursing home, care home and domiciliary care). The ability to further break down the data into categories of care (older peoples' services, learning disability etc) would allow a more meaningful analysis and benchmarking of subsector activity.

As the data becomes more robust it would also be helpful to include unregistered services to provide a rounded understanding of the social care sector in the South East.

SECTION 6 – Conclusions, Opportunities and Recommendations

1. Conclusions and Opportunities

1.1 An imperative to exploit opportunities for business to business collaboration

Both industries have a shared mission to help less able adults to live as independently as possible. Despite the obvious synergies of supply and demand, the two sectors have not done business together. Indeed, despite the millions of pounds which the Department of Health has invested in telecare, only 43% of this project's sample of care providers have accessed assistive technology devices and those in use are largely rudimentary technologies. 78% of these providers want assistance in accessing appropriate technologies but, currently, they have a poor understanding of what telecare offers, who the region's telecare suppliers are, or how to engage with them.

To address the challenges presented by future care needs, the two sectors must work together as market and suppliers to exploit commercially viable opportunities. This transactional relationship will enable the telecare industry to ensure its products are demand-led, commercial viability (ie costed on whole life cycle principles) and beneficial to improving care quality, and delivering efficiencies. The social care sector will be able to specify its needs directly to technology suppliers rather than circuitously through public sector agencies, processes and intermediaries, thus enabling both industries to innovate as well as to address the practical and the ethical issues which can inhibit the uptake of technology in care.

The Government's agencies and its funding will need to be redirected to support this relationship and the resultant transactions, and the impact of this approach should be measured to establish progression in businesses competitiveness, productivity and performance. SEEDA will have a pivotal role to play in brokering this arrangement.

In future, the telecare industry predicts its technologies will have to be available on a much larger scale, involve many more sensors and devices capable of being personalised to individual user needs, be predictive (to allow observation of longer term trends and earlier intervention), and be fully integrated with the care system.

For telecare suppliers, collaborating with the independent care sector has advantages over the statutory sector:

- the business proposition is more straightforward as the number of stakeholders is reduced;
- the supply chain is easier to construct as the response team is largely in place in the form of the current care staff;
- the barriers to investment are lower than in the statutory sector; and
- the independent sector works at the frontline to deliver care services for the customer and, therefore, is best placed to define needs, to implement technologies and to support research and development for future technologies.

1.2 The key issues affecting technology take-up, and recommended solutions

The project's consultations[48] have identified a number of key issues and recommended solutions:

- The capabilities of care's clients – for example, 70% of elderly clients in care homes and end of life care settings have some form of dementia, and they tend to have additional complex needs such as sight, hearing, mobility/dexterity and incontinence disabilities. Therefore, the market for the current telecare offer in this market segment is smaller if there is an expectation that people who use services will use the devices;

[48] Findings are taken from both the survey and the workshop

- Domiciliary care and healthcare providers are growth markets with interest in investing in technology. These segments of the care sector would provide immediate and valuable test bed opportunities;

- Develop marketing data on the commercial viable of assistive technologies, such as cost/benefit analyses, Return on Investment data and other resources to allow care providers to understand the whole life cycle cost of using technologies (including the environmental cost of disposal), and to help the telecare industry to assess the viability of their products;

- Fund test beds and provide access to fully installed assistive technology devices and systems in independent sector care settings where clients, carers and staff can provide advice and feedback to other providers on their experiences of using them;

- Legal, ethical and moral issues need to be resolved, especially those relating to the monitoring and tracking individuals and care workers, and to the perception that telecare leads to isolation. By resolving these issues into a 'code of practice', technology can be used primarily as part of a risk reduction strategy, supporting improved communications as well as supporting care delivery.

- The regulator's understanding of technology needs to change through dialogue and training to establish a consistent approach and to encourage inspectors to become enablers. At present, the perceived 'risks' of using technology rather than people can result in poorer inspection assessments and this is discouraging uptake of technologies. A model of assessment which audits a care service by exception should be developed;

- Assistive technology suppliers need to address the issues relating to interoperability and to the lack of an industry standard for equipment and whole life cycle customer service. These issues are barriers to adoption and they could be address with support from Government agencies.

- Government funding assigned to the procurement of assistive technologies is not reaching the independent care market to enable the industry to purchase against actual needs. Budgets flowing to local authorities are not ring-fenced which can result in funding being used for other priorities. When it is used for procuring assistive technologies, the beneficiaries are usually statutory sector providers or larger providers;

- Care providers need access to independent advice and professional support to help them assess whether technology could deliver improvements.

Telecare is an emerging discipline that really could be an *all win*. Users benefit by being enabled to stay in their chosen setting for longer; the healthcare system benefits by acting in a preventative way and enabling early hospital discharge; government benefits by reduced overall spend; and therefore everyone benefits as taxes are used more efficiently.

2. Recommendations

2.1 Recommendations for improving collaboration across the care sector

In the spirit of "The case for change – Why England needs a new care and support system", the opportunities to make relationships between public and independent sector representatives more effective were examined in Section 5 of this report. In the sub-regions where improvements are required, it is recommended that the following changes are made:

- Establish equal, open and realistic dialogue between public sector and independent providers about commissioning and regulation – ie *consistent, genuine partnerships working*;

- Ensure there are sufficient opportunities for timely consultation and information exchange;
- Make these meetings decision-making forums by ensuring that local authority representatives in attendance are senior enough to make commitments on behalf of each party;
- Establish greater consistency, collaboration and joint activities across the local authority and PCT network to enable the independent sector to engage in a more cost and time-effective way;
- Ensure equality across interested parties;
- Consult with providers to build collaboration and shared values for quality improvements.

2.2 Recommended Next Steps

The clear message is that action is required now. As more adult care providers change their business models to service the needs of private individuals, engagement with public sector agencies becomes less relevant and the urgency to understand policy is diminished. There may be a danger that, if changes are not made in the way the Transformation Agenda is being implemented by Government as described in this report, the influence may shift and the moment may be lost.

4. SEEDA should lead with GOSE/DH on fund work to test out the effectiveness of a SEHTA / SESCA direct, transactional relationship in commissioning and exploiting care-related technologies. This work should include clarifying standards both for addressing social, cultural and ethical issues, and for assessing, installing and ensuring the functionality and interoperability of the technologies.

5. SEHTA should be supported to identify training and skills development needs to enable access to these new markets as part of their work in developing the Science and Innovation Campus, and the skills and competencies required by care-givers to enable them to use assistive technologies should be developed as an integrated competency framework.

6. SESCA and GOSE/DH should open a dialogue to establish how public / private sector relationships need to develop so that partnership working is truly and consistently inclusive, timely, responsive and market-led.

7. SESCA and its network of care associations should be developed as a proven route to engagement for market, skills and policy developments. This will require infrastructure funding and a Concordat to define the relationships between all interested parties. Once in place, the care associations will act as a conduit for advice and to provide access to technological applications and assessment of needs. This will require the definition of skills for an assessor and training to SESCA's local advisers across the region;

8. Care Quality Commission (CQC[49]) must be supported to better understand how to support technology as part of risk assessment.

[49] Care Quality Commission will take over from CSCI as the industry's regulator in April 2009

Appendix I - Glossary of Acronyms and Terms

Acronym	Definition
SME	Small and medium sized enterprises. A company is considered an SME if it has fewer than 250 employees, and has either an annual turnover not exceeding €40 million, or an annual Balance Sheet total not exceeding €27 million. Small firms employ fewer than 50 people, and medium sized firms employ between 51-249 employees.
GVA	Gross Value Added is a measure of economic value and is used in the estimation of Gross Domestic Product (GDP). It measures the difference between the value of goods and services produced and the cost of raw materials and other inputs which are used in production.
Independent sector	In social care, the independent sector is the collective term used for the private and the voluntary sectors, when taken together
NDPBs	Non-Departmental Public Bodies, ie public sector organisations which are not a Central Government departments. These bodies tend to operate through a Remit Letter from a Central Government department and are usually responsible for implementing policy.
BAME	Black, Asian and Minority Ethnic individuals and communities
DH, BERR & DIUS	Central Government departments, in particular: DH: Dept of Health, BERR: Dept for Business, Enterprise & Regulatory Reform, and DIUS: Dept for Innovation, Universities & Skills
SEEDA	South East England Development Agency (Regional Development Agency - or RDA - with responsibility for the economic and social development in their region).
EEDA	East of England Development Agency (Regional Development Agency)
LDA	London Development Agency (Regional Development Agency)
MKOB	Milton Keynes, Oxfordshire and Buckinghamshire
NMDS-SC	National Minimum Dataset – Social Care
CSCI	Commission for Social Care Inspection which, until the end of March 2009, has responsibility for technical inspections and regulation of social care. It is funded by a levy from its industry.
CQC	Care Quality Commission will take over from CSCI as the industry's regulator in April 2009.
Self-funders	Individuals who purchase all or part of their own care through private means.
GSE	The Greater South East consists of three administrative regions: the South East of England, the East of England and London.
LAA	Local Area Agreements are three year agreements which set the priorities for a local area. LAAs are made between central government and a local area, represented by the Government Office, lead local authority and other key partners through Local Strategic Partnerships (LSPs).
LSP	A Local Strategic Partnership is a single non–statutory, multi–agency body, which aims to bring together at a local level the different parts of the public, private, voluntary and community sectors.
Government Offices	Representing 10 Whitehall departments, Government Offices are the primary means by which a wide range of policies are delivered in the English regions. GOSE is the Government office for the South East region.
Skills for Care	Skills for Care is the Sector Skills Council (SSC) representing the interests of adult social care employers in the skills and workforce development arena. They are part of the federated SSC - Skills for Care & Development which represents social care, children and young people's workforces in the UK.

Appendix II – Adult Social Care in the South East & Sector Segmentation

Part 1 – National Minimum Database – Social Care (2007): A profile of the Workforce

This report summarises the data available from the National Minimum Data Set for Social Care (NMDS-SC) in the South East Region. It is based on returns received primarily from social care employers registered with the Commission for Social Care Inspection (CSCI) in the independent sector[50]. The analysis also includes some data from the Commission for Social Care Inspection database.

There are 4,592[51] CSCI-registered establishments in the region providing personal social care to Adults, *including* those managed and run by local authorities. Examples of registered establishments are those providing *personal* care in a residential or day care setting or to a person in their own home (domiciliary services). There are other support services which are not CSCI registered e.g. providing low level help to people in Supported Housing. This analysis of NMDS-SC data is largely of CSCI registered establishments

Note that 'establishment' is not the same as 'employer' since a significant number of employers run more than one establishment. The analysis below provides a break down of the number of CSCI registered establishments owned by the number of employers in the *independent* sector[52].

Scale of Employers' Operations

Table 1: CSCI Registered Services by Number of Establishments Owned by an Employer

Number of Establishments Owned	Number of Owners	Distribution of Owners	Number of Establishments	Percentage of Total Establishments
1	2,277	85%	2,277	53%
2 to 5	295	11%	725	17%
5 to 20	92	3.5%	880	21%
21 plus	12	0.5%	377	9%
Total	2,676	100%	4,259	100%

As can be seen from the third column the majority of proprietors (85%) own only one establishment whereas 3.5% own between 5 and 20 establishments. These figures understate multiple ownership, as some employers will also have businesses outside the Region.

Service User Base

Table 2 below provides a breakdown of the type of service to Adults provided by the independent sector from CSCI data. However, some of these providers may also offer services to children e.g. domiciliary care agencies.

Table 2: Type of Service Provider by Sector

Type of Service Provider	Other	Private	Voluntary	All independent sector
Domiciliary Care Agency	31	628	57	**716**
Care home with Nursing	13	636	44	**693**
Care home only	106	2,129	494	**2,729**
Other	7	115		**121**
All categories	**157**	**3,508**	**595**	**4,259**

[50] This report is the latest version, using data gathered from providers up to 31st May 2007
[51] Source: CSCI Database as at June 2007
[52] There are 333 registered establishments in the statutory sector including local authority and NHS provision. Thus 4,592 minus 333 equals 4,259 independent establishments.

NMDS-SC Returns

This data is based on the first 597 CSCI registered establishments who have provided a NMDS-SC return to Skills for Care i.e. about 14% of the total of independent sector establishments. It includes a small number of establishments providing services to children.

Table 3: Number of NMDS-SC Returns from CSCI registered establishments by Sub Region and Type of Employer

SUB REGION	Statutory	Private	Voluntary	Nk/Other	Total number of Establishments
Berkshire	2	40	15	0	57
Hants &IoW	5	276	18	9	308
Kent & Medway	0	21	20	1	42
Milton Keynes, Oxfordshire and Bucks	0	39	11	1	51
Surrey	2	36	24	4	66
Sussex	1	50	22	0	73
SOUTH EAST	**10**	**462**	**110**	**15**	**597**

Employment

From these returns we can calculate the average number of workers for these establishments and then estimate the total number of staff working in the independent social care sector.

Table 3: Average size of establishment by sub-region

	Number of Establishments	Number of Workers	Average Size
Berkshire	57	1,896	33
Hants &IoW	308	7,335	24
Kent & Medway	42	1,774	42
Milton Keynes, Oxfordshire and Bucks	51	2,144	42
Surrey	66	2,785	42
Sussex	73	3,156	43
SOUTH EAST	597	19,090	32

We can estimate from this that the total number of staff working in CSCI registered social care provision across the region is **147,000**[53] (including local authorities but excluding Children's services)**.**

However, this number is 'head count' rather than the number of employees working full time. In order to estimate the number of whole time equivalent staff we need to use information from elsewhere in the NMDS-SC where data is recorded about individual workers. The data indicates that half the workforce in social care work part time and that the average number of hours worked per week is 20.2 for part time staff and 37.4 for full time. On this basis there are about **113,000** whole time equivalent (FTEs) workers in CSCI registered social care establishments in the South East.

[53] 4,592 CSCI registered establishments multiplied by average of 32 staff equals 146,944. This is largely Adults provision although some providers of domiciliary care also provide services to Children.

Establishment Size
The size of an establishment is defined by the number of employees (micro is less than 10, small is up to 25, medium is up to 250, and large is greater than 250). So far the NMDS-SC has been completed more by smaller than larger establishments, so this distribution is unlikely to be wholly representative of the industry.

Table 4: Size of Establishment Providing NMDS-SC Returns[54]

Large	Medium	Small	Micro	All Sizes
3	110	369	108	590
1%	19%	63%	18%	100%

Service User Category
Table 5 below provides a breakdown of the category of service user by the number of establishments in the NMDS-SC returns to date.

Table 5: Category of Service User by Number of Establishments

Adults	141	23%
Children	16	3%
Families	1	0%
Mixed	66	11%
Older People	365	61%
Unrecorded	11	2%

Note that 'mixed' is overwhelmingly older people and adults. These figures add up to more than 597 as some establishments provide to more than one category of service user.

Services Provided
Table 6 below identifies the services provided by detailed categories. Only the top ten categories in terms of prevalence of services are listed.

Table 6: 'Top Ten' Services provided by CSCI registered establishments responding

Services	**597**
Care home without nursing provision/care only	63%
Care home with nursing provision	17%
Short breaks / respite care	16%
Domiciliary care/home care	15%
Adult placement home	13%
Carers' support	12%
Adult day care service(s)	10%
Domestic services and home help	9%
Other adult residential care service(s)	7%
Other adult domiciliary care service(s)	4%

Note that the services provided exceeds 100% because 70% of establishments offer more than one service in addition to the main CSCI registered one.

The service most often offered, by a long way, is residential care (without nursing), followed by a range of other provision for adults and older people.

[54] Data is for those employers who have specified the number of staff

Capacity and Take Up

The NMDS-SC invites employers to tell us about the capacity of their services and the take up at the point of making a return.

If we just concentrate on the most often offered services residential care for adults was running at 91% of capacity, whilst residential care with nursing provision at 61%. Thus there appears to be a significant amount of over provision in nursing home care in the South East if these results are representative.

The respondent establishments were providing residential care and nursing care for 7,000 adults and older people. The domiciliary care services were providing support for 84,000 people at an average of 5 hours per week per person.

Turnover

Establishments reported that 19% of staff were new in post in the previous 12 months, but this varied somewhat by role. Twenty one percent of direct care staff had left in the previous 12 months. Using this data Table 7 estimates the staff turnover in the past year broken down by job role groups.

Table 7: Turnover of Staff by Job Role Groups[55]

Direct Care / Support providing	21%
Manager/Supervisor	9%
Other	16%
Professional	18%

The highest turnover rates are for those staff providing direct care (21%) closely followed by professionally qualified staff e.g. staff with a nursing or social work qualification. This is shown in Table 8 below.

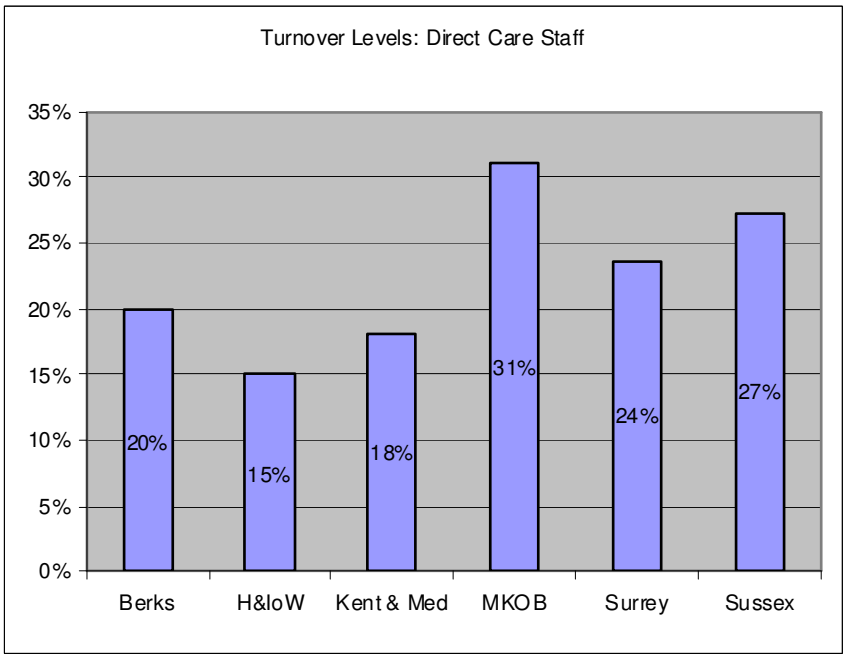
Table 8: Turnover of Staff by Sub Region and Job Role

Sub Reg	Direct Care / Support providing	Manager/ Supervisor	Other	Professional	All Roles	Number of Establishments Responding
Berks	20%	10%	15%	16%	18%	57
H&IoW	15%	6%	10%	13%	13%	308
K&M	18%	8%	13%	23%	17%	42
MKOB	31%	16%	26%	23%	28%	51
Surrey	24%	12%	25%	20%	23%	66
Sussex	27%	8%	16%	21%	23%	73
SOUTH EAST	21%	8%	16%	18%	19%	597

There are considerable differences between sub regions ranging from only a 15% turnover rate of direct care staff in Hampshire and the Isle of Wight to 31% in Milton Keynes, Oxfordshire and Buckinghamshire. This is shown in Chart 1 below.

[55] See Appendix 1 for a breakdown as to which job roles fall into the categories in Table 7.

Chart 1: Turnover Levels: Direct Care Staff



The low turnover rate in Hampshire and the Isle of Wight reflects a very low turnover rate on the Isle of Wight, probably in part due to a less mobile workforce. However, the next lowest turnover rate in direct care staff in Kent and Medway at 18% is considerably less than that in Sussex at 27% and MKOB at 31%.

Caution is needed with respect to some of these turnover rates as the number of establishment responding in some sub regions is relatively small e.g. the response rate in Sussex was 7% and 11% for MKOB. However, for Hampshire and the Isle of Wight the response rate is 32%.

However, if these differences are maintained as more organisations submit their data we will need to try and establish why these rates vary so much given the high costs to employers of staff leaving. The estimated loss nationally of induction training is £78 million per annum. This is likely to translate to a loss of some £10 million in the South East as the largest social care sector out of all the Regions. The loss is likely to be much higher in sub regions with a high turnover rate where there are also a large number of employees i.e. in Sussex.

Investors in People Status & Staff Turnover

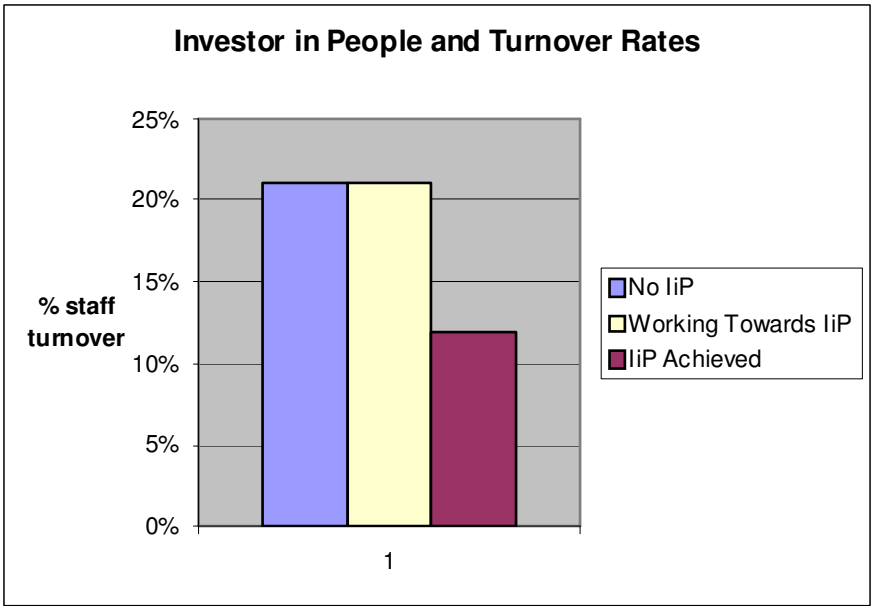
Investment in staff training and development has a significant impact on reducing staff turnover as evidenced by the much lower turnover rate in organisations who have achieved Investor in People Status (IiP). This is shown in Table 9 and Chart 2 below.

Table 9: Investors In People Status And Staff Turnover

IiP status	No of staff	New staff	Turnover
Recognised	4190	485	12%
Committed	1439	295	21%
Neither	13461	2812	21%
All	19090	3592	19%

Whilst achieving Investors in People Status appears to have a significant positive impact on staff turnover, only 14% of establishments in this data set had, or were committed to achieving, IiP status.

Chart 2: Investors in People Status and Staff Turnover



Reason for Leaving and Destination

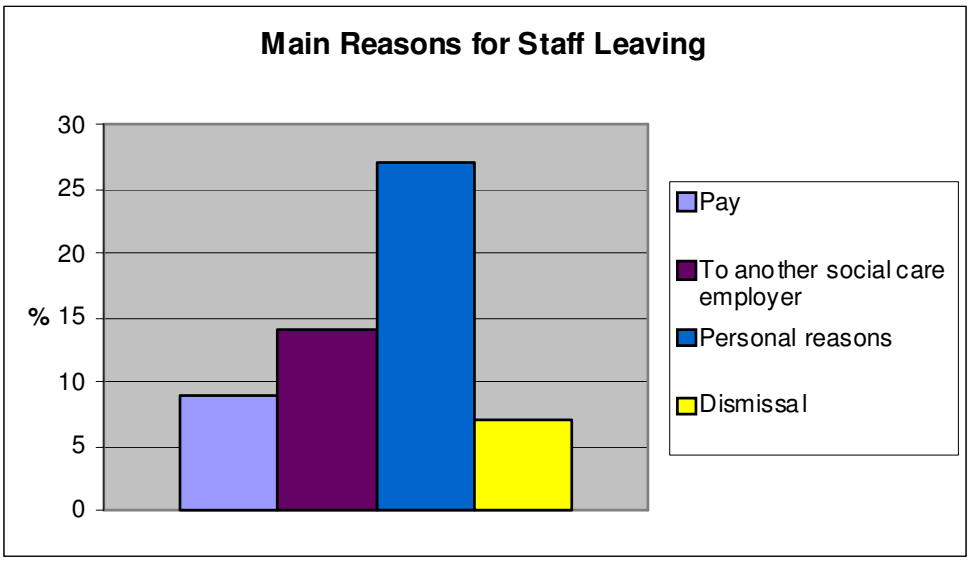
Establishments are also asked to record how many staff have left in the previous 12 months, their reason for leaving and destination. In the previous 12 months 4,068 staff had left – 21% of posts. Reasons for leaving were recorded for 2,607 of these leavers (64%) and is broken down in Table 9.

It is important to note that the reasons for leaving is *as reported by employers* and not necessarily the "real" reasons why staff left. It is known from other research to be published soon that dissatisfaction with management is at least as important as dissatisfaction with pay. Nevertheless the data below does give some insight into why workers have left employment.

Table 9: Reasons for Staff Leaving

Reason (where recorded only)	Number of Staff	Percentage
Pay	241	9%
Conditions of employment	58	2%
Nature of the work	156	6%
Competition from other employers	132	5%
To another social care employer	356	14%
Career development	209	8%
Personal reasons	709	27%
Resignation for other or undisclosed reasons	217	8%
Retirement	132	5%
Death	9	0%
Dismissal	191	7%
Redundancy	50	2%
End of contract term	38	1%
Other reason(s)	109	4%

Chart 3: Reasons for Staff Leaving



The chart above highlights some interesting reasons for staff leaving. Staff leave due to pay in 9% of recorded cases. This is a relatively high reason and was highlighted in the recent national NMDS-SC briefing paper on pay. Rates of pay are a significant challenge for the social care sector and is discussed later in the pay section of the report. However, as noted these reasons are as reported by employers and there may be other significant reasons that are not recorded.

There is also a high dismissal rate at 7%. Does this mean that social care employers are particularly good at spotting poor performance and dealing with it or do recruitment practices need to be improved? Or it may be a combination of both. It will be interesting to compare this with local authority dismissal rates when the data becomes available through NMDS-SC completion by local authorities.

Establishments were also asked where those leavers had gone and that was recorded for 1,393 who had left. The percentages are different in the tables and charts below than indicated in the table and chart above. This is because the destination of leavers has been recorded for a much lower number of staff and hence the numbers on which the analysis is based are smaller.

Employers have a key role in improving the validity of this data by improving their recording of where staff move on to.

Table 10: Destination of Staff Leaving in the South East

Destination of Leavers: South East	Percentage
Adult care sector: private or voluntary sector	29%
Not to another job (straight away)	26%
Adult care sector: local authority	8%
Health sector	7%
Other sector	7%
Abroad	6%
Other destination(s)	5%
Children's sector: private or voluntary sector	4%
Retail sector	4%
Elsewhere within the organisation	3%
Children's sector: local authority	1%

Chart 4: Destination of Staff Leaving in the South East

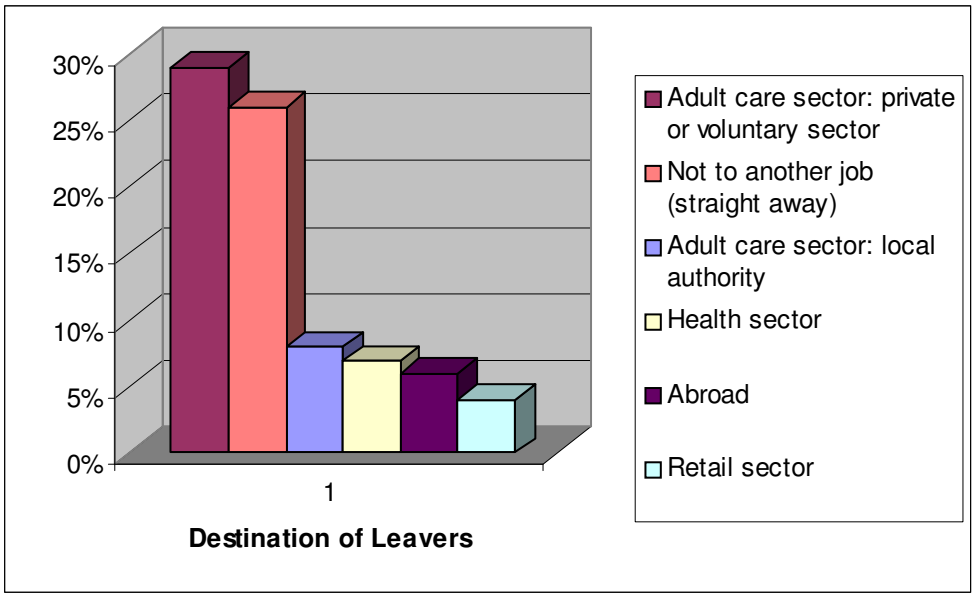


Table 10 shows that of those leaving where the destination has been recorded over 50% remain in the social care or health sector.

As has been found in other Regions the percentage of those leaving to work in the retail sector is very low at 4%. Thus the retail sector does not appear to be a significant competitor for employees working in the social care sector. However, this is not to say that a large number of people employed in the retail sector might otherwise work in the social care sector if made a more attractive option through pay and conditions.

WORKER DATA

Limitations

In the analysis so far we have been using data supplied for a whole establishment. In this section we look at data that is supplied about each individual social care worker which is critical to understanding the social care sector.

Only a minority of employers supplied detailed information about individual workers. For those who did, not all returns are complete i.e. data is not always supplied for all the staff working at the establishment. Other limitations of the data is that Employers may choose not to tell us about more sensitive data such as age or pay of their staff for example.

Caution therefore needs to be exercised in generalising the findings from this small sample of workers to the whole population of workers across the South East.

Table 1: Completeness of return by size of organisation (South East):

Completeness Category	Large	Medium	Small	Micro
Full	33%	37%	23%	27%
Good	0%	3%	3%	4%
Partial	0%	3%	4%	0%
Some	0%	8%	4%	2%
None	67%	48%	66%	66%
All categories	100%	100%	100%	100%

Of those employers submitting NMDS-SC returns a higher proportion of the larger organisations have made full returns of worker data than smaller ones.

In the following tables the base for the analysis is–
"Full returns" means only those organisations that have supplied data on 80% of their staff.
"*All returns"* means that all the worker data supplied for a specific item is analysed.
"*Base*" shows the number of staff for whom data has been given. The closer to 6,369 (for all returns) or 5,680 (for full returns) the more complete is the data.

Gender
Table 2: Gender by Work Role

Role Group	Female	Male
Direct Care	84%	16%
Manager / Supervisor	82%	18%
Other	70%	30%
Professional	89%	11%
All Roles	81%	19%

Base = 6167, all returns

In common with other Regions, social care roles are predominantly undertaken by women. This includes managerial roles in direct care provision.

Ethnicity
32% of workers were described as 'White' and 24% as 'White British'. 'Other groups' were 25%. No other category of ethnicity exceeded 3%. (Base = 3271, all returns)

A more detailed analysis of this data would be necessary to determine whether the ethnicity of workers in the social care sector is representative of, or matches, those being cared for. The sample of workers in each sub Region may be too small to draw any valid conclusions. This will be an important area for investigation when data and benchmarking reports become available through NMDS-SC Online.

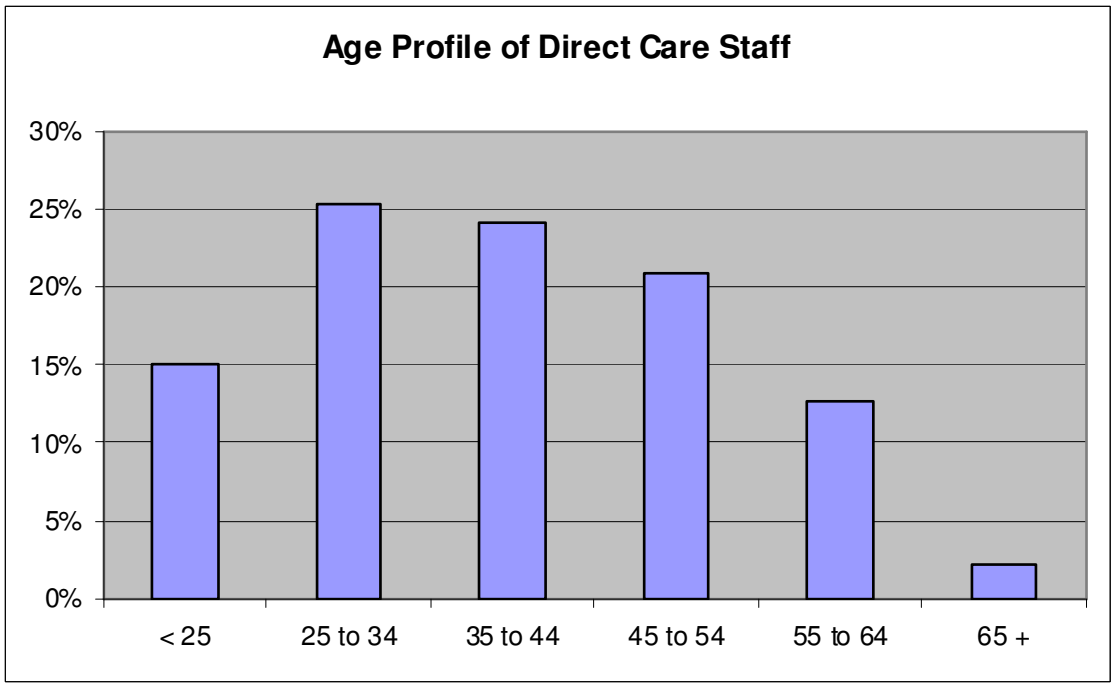
Disability
Only 0.5% of employees were described as having a disability. This is much lower than levels of disability in the working population. This raises a question as to why there are such low levels of disability in this sample of employees. This may be because the majority of these employees are working in direct social care provision, which can involve strenuous physical activity. (Base 5848, all returns)

Age
Table 3 Work Role by Age Category

ROLE GROUP/AGE	< 25	25 to 34	35 to 44	45 to 54	55 to 64	65 +	All Ages
Direct Care	15%	25%	24%	21%	13%	2%	100%
Manager/Supervisor	5%	16%	31%	33%	14%	1%	100%
Other	16%	14%	18%	19%	25%	7%	100%
Professional	2%	21%	30%	36%	10%	1%	100%
All Roles	**14%**	**23%**	**24%**	**22%**	**15%**	**3%**	100%

Base 3802, all returns

Chart 1: Age Profile of Direct Care Staff



As can be seen from the above table and chart the majority of social care workers providing direct care in this dataset are under 45 years of age. 64% of direct care staff were under the age of 45 against the national figure of 50%. Those under the age of 55 in the South East amount to 85% compared to the national figure of 70%. It appears that direct care staff in the South East are considerably younger than is the case nationally and in some other regions. Thus for the independent sector there is currently no risk that a large percentage of direct care staff engaged in social care will be lost through retirement.

However, the age profile for managers is somewhat different with nearly 50% in the 45 to 65+ age groups. A third of managers are in the 45 to 54 age group. Thus the recruitment and retention of experienced social care managers may therefore be a challenge for the future.

It should also be noted that this age profile in the independent sector differs considerably from the age profile of direct care staff in local authorities who have a much older population of workers providing direct social care.

Qualifications

Table 4: Qualifications by Work Role

	Has or working for relevant NVQ	Has or working for Management qualification	Has or working for NVQ level 4 or higher	Base
Direct Care	10%	0%	3%	3,630
Manager/Supervisor	17%	9%	6%	308

Base 5679, full returns

As can be seen from the above table only 10% of direct care workers have a qualification relevant to social care or are working towards one and only 3% have NVQ level 4 or higher. This is well short of the minimum standard being applied by the Commission for Social Care Inspection whereby 50% of employees in direct care roles are expected to have a relevant qualification. The percentage of those in

supervisory roles having qualifications is higher at 17%, with 9% holding or working towards a management qualification and 6% working for NVQ level 4 or higher.

Some caution is needed in drawing definite conclusions as this is a relatively small data set. The issue of what percentage of staff have a relevant qualification will need to be a key line of enquiry as the amount of worker data in NMDS-SC Online builds up.

Pay

Information on pay was provided on 1,508 workers and the median pay levels are identified below. All employee returns where data was provided have been used. Median (or middle) values are used rather than averages as they are far less affected by extreme values.

Table 5: Average Hourly Pay by Work Role

MEDIAN PAY	Hourly Pay £
Direct Care worker	£6.05
Manager/Supervisor	£9.60

The direct care worker's gross median hourly rate of pay in the South East in this dataset is £6.05[56], only a little higher than the care worker's national hourly rate of £5.87. The ONS Annual Survey of Hours and Earnings 2006 identified that check out operators received £6.03 per hour (median) - a very similar rate of pay to those of direct care staff.

As was identified in the section on reasons for staff leaving employment above, pay was cited by employers in 9% of cases. Rates of pay will therefore have an impact on turnover rates with consequent costs to employers. As was asked in the national NMDS-SC Briefing Issue 3: "with such pay rates…how can we recruit, retain and develop a skilled committed and stable workforce?"

As we have seen above in the analysis of the destination of those leaving employment, at least half leave adult social care As noted earlier the loss to the sector based on the estimated costs nationally of induction training of £78 million is likely to result in a loss of some £10 million in the South East as the largest social care sector out of all the Regions. This remains one of the largest challenges to the sector including local authorities who are major commissioners of services[57].

[56] The statutory national minimum wage for people over 22 years was set at £5.52 in October 2007.

[57] Data Analysis and initial commentary by Jeremy Pickard, NMDS-SC Project Manager, Skills for Care, North East Region. Further data analysis, commentary and charts by David Cubey, Workforce Planning and Development Project Manager, Skills for Care, South East. With thanks to Christine Eborall, Programme Head, Skills Research and Intelligence, Skills for Care, for her very helpful comments and observations on the first draft.

Part 2: Market Segment Classifications

In the adult social care sector, the term 'adult' refers to (i) over 16 year olds with learning disabilities or other special needs, and (ii) elderly people who need some form of assistance. The classifications within the adult social care industry are:

1. Assisted Living
2. Domiciliary/home based care
3. Extra Care
4. Care homes
5. Care home with nursing/ Nursing Home
6. Respite & short term care
7. Intermediate care
8. Day care
9. Supported living
10. Continuing care
11. Community care

The descriptions of the key services are:

1. Assisted Living
A supportive housing facility designed for those who need extra help in their day-to-day lives but who do not require the 24-hour skilled nursing care found in traditional nursing homes

2. Domiciliary care
Domiciliary care, otherwise called Home care, is care provided in the individual's own home, enabling them to remain as independent as possible in their own environment.

Domiciliary care is usually provided in chunks of time to help with a specific activity, such as getting up and dressed, assistance bathing, preparing a meal, or shopping. It can include a 'live in carer' who provides 24/7 companionship and care.

Domiciliary Care Agencies employ carers and nurses, and are regulated by the Commission for Social Care Inspection (CSCI). All employees have to undergo a Police Criminal Records Bureau (CRB) check and have to achieve a minimum level of training, but many are trained to a much higher level. Domiciliary care services can be purchase to meet individual needs, and the level can be adjusted needs change.

3. Extra Care
Extra care housing (also known as sheltered housing) is a stepping stone between being able to stay in one's own home, and precedes the decision to go into residential care. Extra care housing is generally purpose built flats or bungalows, often close to or in the grounds of a care home.

Extra Care housing can be purchased, allowing individuals to remain home owners, or rented on a lease basis for a period of time, or a mix of the two. They generally provide an emergency call system within the accommodation giving access to a carer or warden in an emergency.

Extra care housing schemes also offer 24 hour 'personal care' services to assist with personal care needs, such as getting up and dressed, or bathing. Services can be purchased to meet individual needs, in addition to accommodation costs. Many facilities also have restaurants, communal areas to socialise with others, hairdressing and laundry facilities, as well as organised activities and outings.

4. Care Home
A well run care home should feel like a home from home, with the benefits of companionship, outings and activities. Previously called Residential care, a care home provides 24 hour carers to assist with personal care needs, and administer medication. All meals are cooked for individuals and assistance is given to eat them if required.

Additional services may be provided at the care home such as hairdressing, and podiatry services. There will normally be an additional charge for these. The types of services offered differ from care home to care home.

5. Care home with nursing/ Nursing Home
This is very similar to a care home, but with the additional of 24 hour qualified nursing care. This level of care is most suited to those who have health as well as personal care needs. Medication is administered by qualified nurses, as well as dressings, oxygen therapy, nutritional support and other health needs dealt with. Additional services such as physiotherapy, podiatry and hairdressing may be offered at an additional charge.

6. Respite care/ Short term care
Residential care is normally considered long term care, but some people just need care services for a short period of time, perhaps after a hospital stay, or whilst a carer is on holiday. This is known as respite care. Respite care is generally offered in either a care home or care home with nursing, depending on individual's care needs.

The same benefits apply to respite care as to long term care in a care home, such as 24 hour carers or nurses able to assist individuals with individuals care needs, meals cooked for individuals and companionship of others. Respite stays can be from just a few days, up to a number of months dependent on need.

7. Intermediate care
Intermediate care is provided and paid for by the NHS specifically to support someone for up to 6 weeks after a hospital stay or to avoid a hospital admission. The intention of intermediate care is to rehabilitate someone to be able to return home independently or with a level of home care support.

Intermediate care is normally offered in a care home, or care with nursing. Services offered by individual care homes for intermediate care vary, but may include intensive physiotherapy or occupational therapy. Care Homes need to be registered with CSCI specifically for intermediate care in order to be allowed to provide it to individuals.

8. Day Care
Day care may just be the level of support an individual needs to stay at home a little longer. Day care is offered in a variety of settings to meet a wide variety of needs. Some Charities for specific conditions such as The Alzheimer's Society provide day care centres to allow people with Alzheimer's to socialise together and enjoy a meal cooked for them, and to give family and carers a few hours break.
Care homes or care homes with nursing can be registered with CSCI to provide day care services. These are generally a bit more structured than day centres and can offer additional services such as bathing and foot care, as well as socialising and enjoying a meal.

9. Supported Living
Supported Living schemes for people with learning disabilities or mental health problems allows individuals to remain independent by having their own front door, but to know a support worker is available should individuals need them. The individual flats or accommodation within a shared house are based within the heart of communities. Most accommodation in Supported Living schemes is leased by

the tenant. It offers a viable alternative to full residential care to people with learning disabilities and mental health problems.

Supported Living schemes can offer so much more than secure comfortable accommodation and personal care services. They can offer guidance on daily living skills in order to increase independence, and can support someone into employment or education.

Most Supported Living Schemes are run by local councils or charitable organisations, Social Services can help individuals find the right place to live.

10. Continuing Care
Sometimes called long-term care, is specialist care provided and paid for by the NHS, either in hospital or a nursing home.

11. Community Care
Community care is provided outside hospitals, in your own home or in a residential or nursing home. For older people, community care is social or nursing care rather than specialist nursing care.

Appendix III: Data Tables: Strategic Framework for benchmarking the adult social care sector

SE Workforce Benchmarking Data

Source: NMDS-SC Period Dec 2008

Author: David Lambert

Establishments			Manager		BAME						Gender			Disability	
CSCI Registered	NMDS participation	% NMDS Participation		Responses	White	Asian	Black	Mixed	Other	Unknown	M	F	Unknown	Disabled	Unknown
1,089	636	58%	**Sussex**	227	84%	4%	2%	0%	3%	7%	17%	81%	3%	2%	6%
601	367	61%	**Surrey**	110	68%	6%	2%	1%	10%	13%	12%	80%	8%	0%	11%
943	563	60%	**Hampshire IOW**	156	85%	4%	1%	1%	1%	9%	15%	79%	6%	1%	11%
468	326	70%	**MKOB**	111	68%	0%	4%	1%	5%	21%	10%	76%	14%	0%	18%
346	229	66%	**Berkshire**	108	68%	2%	3%	0%	2%	25%	8%	67%	25%	1%	29%
982	547	56%	**Kent & Medway**	135	76%	3%	1%	1%	4%	15%	15%	76%	9%	0%	11%
4,429	2,681	61%	SE	847	77%	3%	2%	1%	4%	14%	13%	77%	9%	1%	13%
23,507			England	5,660	77%	2%	3%	1%	2%	14%	15%	76%	9%	1%	15%

Senior Care Worker		BAME						Gender			Disability	
	Responses	White	Asian	Black	Mixed	Other	Unknown	M	F	Unknown	Disabled	Unknown
Sussex	836	63%	5%	3%	1%	3%	24%	13%	85%	2%	1%	8%
Surrey	299	45%	13%	13%	0%	5%	23%	9%	77%	14%	0%	23%
Hampshire IOW	613	77%	6%	3%	0%	3%	11%	11%	83%	6%	0%	14%
MKOB	409	60%	7%	9%	2%	2%	20%	9%	81%	10%	0%	15%
Berkshire	344	54%	5%	14%	3%	7%	18%	14%	69%	16%	1%	22%
Kent & Medway	527	76%	5%	4%	1%	4%	10%	15%	78%	7%	1%	12%
SE	3,028	65%	6%	6%	1%	4%	18%	12%	80%	8%	1%	14%
England	20,665	72%	5%	5%	1%	2%	15%	12%	79%	9%	1%	17%

Care Worker		BAME						Gender			Disability	
	Responses	White	Asian	Black	Mixed	Other	Unknown	M	F	Unknown	Disabled	Unknown
Sussex	4,747	58%	4%	5%	1%	3%	30%	16%	81%	3%	1%	19%
Surrey	2,786	39%	4%	15%	0%	12%	30%	13%	76%	11%	1%	26%
Hampshire IOW	4,512	59%	4%	6%	1%	2%	29%	12%	83%	4%	1%	29%
MKOB	3,206	38%	4%	10%	0%	2%	45%	12%	75%	12%	0%	31%
Berkshire	2,761	33%	5%	12%	1%	5%	44%	12%	66%	22%	1%	49%
Kent & Medway	3,655	49%	3%	4%	0%	5%	38%	11%	83%	6%	0%	35%
SE	21,667	48%	4%	8%	1%	4%	35%	13%	78%	9%	1%	30%
England	150,529	59%	3%	7%	1%	2%	28%	12%	79%	9%	1%	27%

Notes:

'Unknown' includes respondents who did not answer. High percentages may mask a bias in the data.

Asian includes Asian and Asian British

Black includes Black and Black British

Percentages rounded to the nearest whole number

SUSTAINABLE SOCIAL CARE PROCUREMENT

Project Report

SE Workforce Benchmarking Data

Source: NMDS-SC Period Dec 2008

Author: David Lambert

Establishments			Manager		Age					Wages		Turnover	NVQ4	
CSCI Registered	NMDS participation	% NMDS Participation		Responses	<20	20-34	35-54	>54	Unknown	Median hour	Responses	%	Achieved	Working to
1,089	636	58%	Sussex	227	0%	8%	58%	26%	8%	£13.00	23	12%	38%	5%
601	367	61%	Surrey	110	0%	12%	63%	19%	6%	£12.93	4	11%	25%	7%
943	563	60%	Hampshire IOW	156	0%	17%	61%	18%	6%	£11.21	14	9%	60%	13%
468	326	70%	MKOB	111	0%	8%	62%	24%	5%	£16.88	10	9%	42%	6%
346	229	66%	Berkshire	108	0%	15%	55%	23%	7%	£10.91	5	7%	49%	11%
982	547	56%	Kent & Medway	135	0%	11%	61%	22%	5%	£11.41	24	9%	36%	12%
4,429	2,681	61%	SE	847	0%	12%	60%	22%	6%	£12.50	80	10%	42%	9%
23,507			England	5,660	0%	10%	59%	22%	10%	£12.00	648	10%	40%	11%

Senior Care Worker		Age					Wages		Turnover
	Responses	<20	20-34	35-54	>54	Unknown	Median hour	Responses	%
Sussex	836	0%	32%	49%	15%	5%	£6.75	389	11%
Surrey	299	0%	21%	44%	17%	17%	£7.65	103	10%
Hampshire IOW	613	0%	28%	48%	16%	8%	£6.58	266	8%
MKOB	409	0%	21%	46%	18%	14%	£7.62	217	9%
Berkshire	344	0%	28%	42%	18%	12%	£7.15	101	8%
Kent & Medway	527	0%	31%	48%	17%	4%	£6.46	278	10%
SE	3,028	0%	27%	47%	17%	9%	£7.00	1,354	9%
England	20,665	0%	26%	48%	16%	10%	£6.45	9,442	10%

Care Worker		Age					Wages		Turnover
	Responses	<20	20-34	35-54	>54	Unknown	Median hour	Responses	%
Sussex	4,747	2%	34%	43%	16%	5%	£6.35	1,905	22%
Surrey	2,786	1%	35%	41%	15%	9%	£6.81	872	18%
Hampshire IOW	4,512	3%	33%	39%	12%	12%	£6.25	1,814	24%
MKOB	3,206	1%	32%	40%	13%	13%	£6.96	1,584	18%
Berkshire	2,761	1%	31%	38%	11%	19%	£6.80	744	19%
Kent & Medway	3,655	3%	33%	45%	14%	6%	£6.10	1,818	23%
SE	21,667	2%	33%	41%	14%	10%	£6.45	8,737	21%
England	150,529	2%	31%	42%	15%	11%	£6.10	64,633	20%

SE Capacity Benchmarking Data

South East Registered Services

Source: CSCI Website (Jan 09)

Sussex

Note: Many care beds are registered for more than one category of care

Nursing Homes

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	193	22	4	1	1	221	8602	38.92
Older People	140	12	2	0	26	180	7124	39.58
Dementia	48	7	2	0	0	57	2851	50.02
Physical Disability	77	8	0	1	0	86	3648	42.42
Learning Disability	194	31	22	10	1	258	2149	8.33
Mental Health	18	3	1	0	0	22	1003	45.59

Care Homes (without nursing)

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	560	82	32	10	1	685	12492	18.24
Older People	225	35	4	0	16	280	7515	26.84
Dementia	118	6	5	0	0	129	3651	28.30
Physical Disability	28	10	2	0	0	40	86	22.00
Learning Disability	194	31	22	10	1	258	2149	8.33
Mental Health	74	4	3	0	0	81	1562	19.28

Dom Care

Type of ownership					Registered services		
Private	**Vol**	**LA**	**NHS**	**Other**	Total		
145	17	16	1	4	183		

SE Capacity Benchmarking Data

South East Registered Services

Source: CSCI Website (Jan 09)

Surrey

Note: Many care beds are registered for more than one category of care

Nursing

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	105	10	0	0	3	118	5271	44.67
Older People	79	5	0	0	15	99	4759	48.07
Dementia	67	5	0	0	1	73	3646	49.95
Physical Disability	24	6	0	0	0	30	1433	47.77
Learning Disability	8	0	0	0	0	8	336	42.00
Mental Health	19	3	0	0	1	23	855	37.17

Care Homes (without nursing)

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	252	78	11	3	30	374	6182	16.53
Older People	80	29	6	0	0	115	3743	32.55
Dementia	80	28	8	0	1	117	3777	32.28
Physical Disability	31	32	5	3	0	71	2098	29.55
Learning Disability	152	44	6	30	2	234	2088	8.92
Mental Health	45	13	3	0	0	61	1402	22.98

Dom Care

Type of ownership					Registered services		
Private	Vol	LA	NHS	Other	Total		
75	8	12	0	14	109		

SE Capacity Benchmarking Data

South East Registered Services

Source: CSCI Website (Jan 09)

Hampshire I.O.W.

Note: Many care beds are registered for more than one category of care

Nursing

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	131	12	9	0	1	153	6622	43.28
Older People	95	6	10	0	10	121	5454	45.07
Dementia	50	5	10	0	8	73	37.3	51.10
Physical Disability	69	4	0	0	1	74	3201	43.26
Learning Disability	9	0	1	0	0	10	299	29.90
Mental Health	17	4	0	0	0	21	1030	49.05

Care Homes (without nursing)

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	469	79	38	12	3	601	10143	16.88
Older People	238	11	21	0	3	273	7068	25.89
Dementia	206	4	21	0	2	233	6163	26.45
Physical Disability	81	15	7	0	0	103	2540	24.66
Learning Disability	202	49	12	12	0	275	2184	7.94
Mental Health	135	5	0	0	0	140	2699	19.28

Dom Care

Type of ownership					Registered services		
Private	Vol	LA	NHS	Other	Total		
144	28	8	1	8	189		

SE Capacity Benchmarking Data

South East Registered Services

Source: CSCI Website (Jan 09)

M.K.O.B.

Note: Many care beds are registered for more than one category of care

Nursing

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	78	17	0	0	5	100	4771	47.71
Older People	62	10	0	0	15	87	4294	49.36
Dementia	38	6	0	0	7	51	2985	58.53
Physical Disability	14	6	0	0	0	20	939	46.95
Learning Disability	7	1	0	0	0	8	386	48.25
Mental Health	11	1	0	0	0	12	642	53.50

Care Homes (without nursing)

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	113	112	2	5	3	235	4331	18.43
Older People	70	35	0	0	4	109	3257	29.88
Dementia	40	31	1	0	3	75	2436	32.48
Physical Disability	19	43	0	4	1	67	1459	21.78
Learning Disability	44	55	1	5	0	105	963	9.17
Mental Health	16	11	0	1	1	29	572	19.72

Dom Care

Type of ownership					Registered services		
Private	Vol	LA	NHS	Other	Total		
84	19	20	5	5	133		

SE Capacity Benchmarking Data

South East Registered Services

Source: CSCI Website (Jan 09)

Berkshire

Note: Many care beds are registered for more than one category of care

Nursing

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	39	6	1	0	0	46	2472	53.74
Older People	36	4	1	0	1	42	2202	52.43
Dementia	20	2	0	0	0	22	1394	63.36
Physical Disability	13	2	1	0	0	16	882	55.13
Learning Disability	0	0	0	0	0	0	0	0.00
Mental Health	2	0	0	0	0	2	79	39.50

Care Homes (without nursing)

	Type of ownership					Registered services		
	Private					Total		
All	168	29	21	0	1	219	2745	12.53
Older People	46	3	11	0	0	60	1509	25.15
Dementia	11	0	8	0	1	20	624	31.20
Physical Disability	15	3	1	0	0	19	182	9.58
Learning Disability	118	26	5	0	0	149	971	6.52
Mental Health	4	2	2	0	0	8	92	11.50

Dom Care

Type of ownership					Registered services		
Private	Vol	LA	NHS	Other	Total		
56	8	9	0	8	81		

SE Capacity Benchmarking Data

South East Registered Services

Source: CSCI Website (Jan 09)

Kent & Medway

Note: Many care beds are registered for more than one category of care

Nursing

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	100	4	4	0	0	108	5000	46.30
Older People	65	4	4	0	16	89	4283	48.12
Dementia	32	3	3	0	2	40	2284	57.10
Physical Disability	22	0	0	0	0	22	1065	48.41
Learning Disability	4	0	0	0	0	4	82	20.50
Mental Health	4	0	1	0	0	5	208	41.60

Care Homes

	Type of ownership					Registered services		
	Private	Vol	LA	NHS	Other	Total	Beds	Mean
All	579	94	22	0	19	714	11960	16.75
Older People	209	10	15	0	8	242	6713	27.74
Dementia	97	10	5	0	2	114	3788	33.23
Physical Disability	30	10	2	0	0	42	771	18.36
Learning Disability	280	69	6	0	4	359	2933	8.17
Mental Health	49	4	0	0	1	54	753	13.94

Dom Care

Type of ownership					Registered services		
Private	Vol	LA	NHS	Other	Total		
116	19	7	1	17	160		

Appendix IV: Telecare Firms and Universities

1. Telecare Firms in the Greater South East (GSE)

Company	Region	City	Address	Postcode	Website	Employees Last Year	Revenue Last Year	Last Reporting Year
CIRRUS COMMUNICATION SYSTEMS LIMITED	Southampton	New Milton	11 Queensway	BH25 5NR	www.cirruscom.co.uk	133	£10,244	2006
MOON Communications International Limited	Brighton	Brighton	Queens Park Villa, 30 West Drive	BN2 2GE	www.mooncom.co.uk			
WEALDEN AND EASTBOURNE LIFELINE (WELBEING)	Brighton	Eastbourne		BN21 3UH	www.welbeing.org.uk			
PATEX UK LTD	Greater London South	Bromley	21 East Street	BR1 1QE	www.airwave-technology.com			2007
DATASCOPE MEDICAL CO. LIMITED	Cambridge - Peterborough	Huntingdon	Lakeview Court, Spitfire Close /	PE29 6XR	www.datascope.com	31	£9,664	2006
ADASTRA SOFTWARE LIMITED	Canterbury - Medway-Tonbridge	Ashford	Unit 4 / Eurogate Business Park	TN24 8SB	www.adastra.co.uk	134	£10,200	2006
RED ALERT LIMITED	Canterbury - Medway-Tonbridge	Ashford	3 The Courtyard Orbital Park, Sevington	TN24 0SY	www.redalertuk.com			2006
REMOTE CONNECTIONS LIMITED	Canterbury - Medway-Tonbridge	Deal	17 Mill Road	CT14 9AH	www.rconnections.com			2006
HUGH STEEPER LIMITED	Canterbury - Medway-Tonbridge	Rochester	Medway City Estate / 51 Riverside / 2 Medway City Estate	ME2 4DP	www.rslsteeper.co.uk		£22,611	2006

Company	Region	City	Address	Postcode	Website	Employees Last Year	Revenue Last Year	Last Reporting Year
RSL STEEPER HOLDINGS LIMITED	Canterbury - Medway-Tonbridge	Rochester	Riverside Orthopaedic Centre / 51 Riverside Medway City Estate	ME2 4DP	www.rslsteeper.com	458	£29,288	2006
AXON (UK) LIMITED	Chelmsford - Colchester - Southend-on-Sea	Billericay	Lakeview House / 4 Woodbrook Crescent	CM12 0EQ				2006
INFODISP	Guildford	Bordon	Information & Display Systems Limited , 12 Woolmer Way	GU35 9QF	www.infodisp.com			
ROKE MANOR RESEARCH LIMITED	Guildford	Camberley	Faraday House / Sir William Siemens Square	GU16 8QD	www.roke.co.uk	427	£40,352	2006
POSITION SYSTEMS LIMITED	Guildford	Farnham	4 Orchard Court / Church Street, Crondall	GU10 5QP	www.bloodhoundcomms.com			2005
KARTEN NETWORK LTD	Guildford	Godalming	Ashcombe Court / Woolsack Way	GU7 1LQ				2006
CARDIAK LIMITED	Inner London	London	21 Wilson Street	EC2M 2TD				2006
FOUNDATION FOR ASSISTIVE TECHNOLOGY	Inner London	London	12 City Forum / 250 City Road	EC1V 8AF	www.fastuk.org	5		2006
SPACELABS MEDICAL UK LIMITED	Inner London	London	110 Cannon Street	EC4N 6AR		41	£6,039	2007
SUNRISE OPERATIONS BASSETT LIMITED	Inner London	London	8th Floor / 68 King William Street	EC4N 7DZ		36	£320	2006
SUNRISE OPERATIONS EDGBASTON LIMITED	Inner London	London	8th Floor / 68 King William Street	EC4N 7DZ		29	£892	2006
SUNRISE OPERATIONS ESHER LIMITED	Inner London	London	8th Floor / 68 King William Street	EC4N 7DZ		36	£1,359	2006
SUNRISE OPERATIONS FLEET LIMITED	Inner London	London	8th Floor / 68 King William Street	EC4N 7DZ		33	£1,416	2006

Company	Region	City	Address	Postcode	Website	Employees Last Year	Revenue Last Year	Last Reporting Year
SUNRISE OPERATIONS GUILDFORD LIMITED	Inner London	London	8th Floor / 68 King William Street	EC4N 7DZ		32	£1,170	2006
SUNRISE OPERATIONS WESTBOURNE LIMITED	Inner London	London	8th Floor / 68 King William Street	EC4N 7DZ		34	£1,407	2006
T+ MEDICAL LIMITED	Inner London	London	c/o Druces & Attlee / Salisbury House London Wall	EC2M 5PS			£883	2007
UK EHEALTH ASSOCIATION	Inner London	London	55 Gower Street	WC1E 6HQ			£35	2006
RICHMOND PAINSWICK LIMITED	Inner London	London	Suite 201 The Chambers	SW10 0XF		8	£844	2006
TROCHUS PLC	Inner London	London	1 Deans Yard	SW1P 3NP	www.trochusplc.co.uk	7	£349	2007
LIFEWATCH UK LIMITED	Inner London	London	22 Upper Wimpole Street	W1G 6NB				2006
VIRTUAL COMMUNICATIONS NETWORK (UK) LIMITED	Inner London	London	16 Dover Street	W1S 4LR				2005
GN RESOUND LTD	Oxford	Bicester	1 Landscape Close / Weston On The Green	OX25 3SX	www.gnresound.co.uk	103	£16,193	2006
SMARTSENSOR TELEMED LIMITED	Oxford	Didcot	Harwell Innovation Centre / Harwell International Business /	OX11 0QG			£43	2006
BOX TECHNOLOGIES LIMITED	Oxford	Thame	20 Thame Park Business Centre / Wenman Road	OX9 3XA	www.boxtechnologies.com	59	£19,235	2007
VISIONRADIO LIMITED	Portsmouth	Portsmouth	12 Fratton Road	PO1 5BX	www.visionradio.net			2006
FIRST CONNECTIONS LIMITED	Reading - Slough	Basingstoke	5 Faraday Office Park / Faraday Road Basingstoke	RG24 8QQ	www.firstconnections.co.uk			2006
ATS MediRent	Reading - Slough	Bracknell	Magnum House, Cookham Road	RG12 1RB				

Company	Region	City	Address	Postcode	Website	Employees Last Year	Revenue Last Year	Last Reporting Year
FUJITSU SIEMENS COMPUTERS LIMITED	Reading - Slough	Bracknell	Fsc Campuse / The Boulevard Cain Road	RG12 1HH	www.fujitsu-siemens.com	278	£378,613	2006
ISEEUGLOBAL Ltd	Reading - Slough	Bracknell		RG12 1WA	www.iseeuglobal.com			
SIGNATURE SENIOR LIFESTYLE HOLDINGS LIMITED	Reading - Slough	Gerrards Cross	Shire House / West Common	SL9 7QN		145	£1,869	2006
TRITEQ LIMITED	Reading - Slough	Hungerford	3 The Courtyard / Stype	RG17 0RE	www.triteq.com			2006
ST Microelectronics	Reading - Slough	Marlow	Planar House, Parkway Globe Park	SL7 1YL	www.st.com			
BASIC COMFORTS LIMITED	Reading - Slough	Reading	16 Beta House, Southcote Road	RG30 2AR			£15	2005
MEDIAGRIDS PLC	Reading - Slough	Reading	Unit 8C / Castle End Business Park	RG10 9XQ		9	£39	2007
iTELECARE	Reading - Slough	Wokingham		RG40 3PJ	www.itelecare.co.uk			
VIVATEC LIMITED	Reading - Slough	Wokingham	Crane House / Molly Millars Lane	RG41 2RZ				2006
SPECIALIST MEDICAL INTERNATIONAL LTD.	Redhill	Crawley	12 Gleneagles Court / Brighton Road	RH10 6AD				2006
NAVIGIL LTD	Redhill	Dorking		RH4 1AR				
MEDEQUIP ASSISTIVE TECHNOLOGY LIMITED	Greater London South	West Drayton	Unit 2 Summit Centre / Skyport Drive Harmondsworth	UB7 0LJ	www.medequipuk.com	218	£26,830	2006
ORTIVUS UK LIMITED	Southampton	Southampton	39-49 Commercial Road	SO15 1GA	www.ortivos.co.uk	4	£769	2007
LIVING INDEPENDENTLY LIMITED	Southampton	Winchester	New Barn Court / New Barn Lane	SO21 2PP				2006

Company	Region	City	Address	Postcode	Website	Employees Last Year	Revenue Last Year	Last Reporting Year
PHARMA COMMUNICATIONS LIMITED	Aylesbury	Amersham	42 Long Park	HP6 5LA			£16	2007
SRS TECHNOLOGY LTD.	Aylesbury	Aylesbury	8 Farmbrough Close / Stocklake Park Industrial Estate	HP20 1DQ	www.srstechnology.co.uk			2006
FVC.COM	Aylesbury	Beaconsfield	22, Wycombe End	HP9 1NB	www.fvc.com			
SUNRISE OPERATIONS BANSTEAD LIMITED	Aylesbury	Beaconsfield	Crofton House / 16 Warwick Road	HP9 2PE		67	£4,513	2006
SUNRISE OPERATIONS ELSTREE LIMITED	Aylesbury	Beaconsfield	Crofton House / 16 Warwick Road	HP9 2PE		31	£4,158	2006
SUNRISE OPERATIONS MOBBERLEY LIMITED	Aylesbury	Beaconsfield	Crofton House / 16 Warwick Road	HP9 2PE		20	£20	2006
SUNRISE OPERATIONS PURLEY LIMITED	Aylesbury	Beaconsfield	Crofton House / 16 Warwick Road	HP9 2PE		46	£2,194	2006
SUNRISE OPERATIONS UK LIMITED	Aylesbury	Beaconsfield	Crofton House / 16 Warwick Road	HP9 2PE		46	£6,057	2006
SUNRISE OPERATIONS V.W. LIMITED	Aylesbury	Beaconsfield	Crofton House / 16 Warwick Road	HP9 2PE		33	£4,581	2006
SUNRISE SENIOR LIVING LIMITED	Aylesbury	Beaconsfield	Crofton House / 16 Warwick Road	HP9 2PE	www.sunrise-care.com	38	£6,865	2005
MULTISENSE COMMUNICATIONS LTD	Aylesbury	High Wycombe	Red Lion House / 600 London Road	HP11 1EX	www.multisense.co.uk			2006
VEGA GROUP PLC	St. Albans - Hemel Hempstead	Welwyn Garden City	2 Falcon Way / Shire Park / Welwyn Garden City	AL7 1TW	www.vega-group.co.uk	616	£64,120	2007
TANDBERG	Guildford	Staines	Unit 2, Pine Trees, Chertsey Lane	TW18 3HR	www.tandberg.com			

2. University Excellence in Telecare in the South East Region

SEEDA Region's Universities' Core telecare research activities			
Bucks New University, Telehealth Research Group	Bucks	• Provision of paediatric cardiology advice using ISDN-2 technology • Telemedicine to support stroke rehabilitation • Review of patients with chronic fatigue syndrome by telemedicine • Telemedicine for provision of care of patients with spinal cord injury	www.bucks.ac.uk
Open University, Clinical E-Science Framework	Bucks	Project designed to provide clinicians and GPs with easy access to accurate and relevant information about patients at the point of care – thus eliminating the need for the extensive research of paper-based files.	www.open.ac.uk
Oxford Brookes University	Oxfordshire	Ambulatory patient monitoring	www.tech.brookes.ac.uk
University of Oxford	Oxfordshire	Telemonitoring, signal processing: spin out: T+ Medical	www.ox.ac.uk
Brunel University, Health Economics Research Group	Middlesex	Economic evaluation of a broad range of clinical and health service technologies and its dual aim is to provide applied, policy-relevant research whilst developing and refining methods to increase the rigour and relevance of such studies.	www.brunel.ac.uk
Brunel University, MATCH	Middlesex	Support the healthcare technology sector and its user communities by creating methods to assess value from concept through to mature product and by engaging with regulatory bodies at home and abroad'.	www.match.ac.uk
Brunel University, Centre for Health Informatics and Computing (CHIC)	Middlesex	Information and knowledge management	www.brunel.ac.uk
Brunel University	Middlesex	European project: DIADEM- provide an adaptable web browser interface, to enable people who suffer a reduction in cognitive	www.brunel.ac.uk

SEEDA Region's Universities' Core telecare research activities			
		skills to remain active and independent members of society both at work and at home.	
Brunel University, Institute for Bioengineering	Middlesex	The development of telecare devices and systems to meet the need for independence of an ageing population	www.brunel.ac.uk
University of Kent, Centre for Health Services Studies	Kent	Evaluation of telecare	www.kent.ac.uk/chss
University of Reading, EQUAL network	Bucks	Improve the living environments and hence the quality of life of older people and disabled people by promoting interdisciplinary engineering based research and its application.	www.extra.reading.ac.uk/equal/network.htm
University of Reading, Built Environment	Bucks	Housing, internal environment, assistive technology in home	www.extra.reading.ac.uk/ie
University of Portsmouth	Hants	Telecare Knowledge Network, telemedicine and e-health information service, expertise in evaluation of telecare, health informatics, telecare product development	www.port.ac.uk
University of Surrey	Surrey	Telemonitoring, evaluation, centre for communications systems research	www.portal.surrey.ac.uk
Kingston University, Mobile Information and Network Technologies Centre	Surrey	Security issues in healthcare, personalised healthcare, emerging wireless healthcare management, intelligent mobile healthcare	www.cism.kingston.ac.uk/momed/rsch
University of Southampton, School of health professions and rehabilitation sciences	Hants	Computer assisted rehabilitation, smart clothing	www.sohp.soton.ac.uk

3. Associated telecare research

Associated telecare research			
Cranfield	Bedfordshire	Healthcare operations management, translational medicine, cyber security	www.cranfield.ac.uk
Royal Holloway	Surrey	ICT for development	www.gg.rhul.ac.uk
University of Winchester	Winchester	Course in managing e-health and telemedicine	www.winchester.ac.uk
University of Greenwich	Greenwich	Teaching in provision of care services	www.gre.ac.uk
University of Buckingham	Bucks	Background capability in imaging and telemedicine	www.buckingham.ac.uk
University of Sussex	Sussex	Informatics, human-computer interface, sensor development	www.sussex.ac.uk