Research into prevention in adult social care

Final report

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Skills for Care is the provider-led strategic body for workforce development in social care for adults in England. It is part of the sector skills council, Skills for Care and Development.

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Executive summary

Introduction

This is a report of findings from an independent research study into prevention in the adult social care sector in England. Undertaken between March and October 2019, the study was commissioned by Skills for Care and was carried out by a team of researchers from York Consulting LLP. The research involved consultation with commissioners of adult social care services and adult social care providers.

Aims and approach

The research was commissioned in order to strengthen the evidence base on the following topics:

- Social care providers' definitions and understanding of prevention in adult social care;
- Social care providers' views on the importance of prevention and the ease or difficulty with which it can be implemented;
- The impacts of prevention activities on people who access care and support services, employees working in the sector and adult social care providers;
- Commissioners' views on prevention;
- The implications of the prevention agenda for adult social workforce development.

Input was obtained from over 300 adult social care providers via a quantitative telephone survey and one-to-one qualitative consultations. The composition of the final sample was 53% residential providers and 47% non-residential. This broadly reflects the composition of the sector nationally, where 49% of care providing establishments are residential and 51% are non-residential.

Eleven local authority commissioners took part in a bespoke online consultation exercise.

Defining prevention

Prevention in adult social care does not have a single or homogenous definition, although four consistent themes emerged from the research:

- Helping those who access care and support to live as healthily as possible;
- Helping to reduce the use of health services;
- Preventing or reducing the escalation of health issues;
- Supporting people to remain as independent as possible.

Social care providers and commissioners agree that prevention is, or should be,

embedded within the business-as-usual delivery of high-quality adult social care. It is not a standalone task or activity. It includes monitoring and tracking of the physical and mental health of people accessing care and support, supporting and advising them with diet, nutrition and exercise, developing close working relationships with staff in related sectors and supporting care staff with their own mental health and wellbeing.

Implementation and impacts

The key enablers of effective prevention are the same as those that drive effective practice in the sector more broadly. They include leadership, staff knowledge and skills, effective communication and strong working relationships with colleagues working in other parts of the health and care system. However, time and financial resources prevent some social care providers from embedding prevention in their work as quickly or on the scale that they would like.

Social care providers were consistently positive about the impacts of prevention, particularly in terms of how it reduces the escalation of need and leads to better outcomes for people receiving care and support. They also spoke of satisfaction levels amongst those who access care and support and their families being higher and of organisational reputations having been enhanced.

Workforce benefits are also evident: three-quarters of the social care providers said that prevention had helped them to deliver their organisation's aims, that it had improved their employee's self-awareness regarding their own health and wellbeing and/or that it had increased levels of job satisfaction. It was very rare for providers to say that prevention had resulted in any negative or unwanted outcomes.

Commissioning and prevention

Three-quarters of providers agreed that prevention is a focus for local commissioners, although there is some uncertainty around commissioners' specific expectations. This is reflected in the fact that half the providers said the priorities of local commissioners had neither helped nor hindered their ability to implement prevention activities.

The commissioners in the research sample agreed that prevention is becoming more prevalent within commissioning specifications but is not yet universal or consistent. Whilst over time they would expect it to be cited overtly within all specifications, there is nonetheless a current expectation that prevention should feature prominently in the delivery of care and support services. They spoke, for example, of contracts referencing co-production, strengths-based approaches and the importance of self-care, all of which have direct links to prevention.

Looking ahead

More than half of the providers have plans to either increase the scale and/or reach of their current prevention activities, while more than a third plan to introduce new activities. Providers are uncertain about how prevention will impact on the composition

of the sector's workforce and the skillsets of different job roles, even where they are confident that some such change will occur over the coming years.

There is an appetite amongst providers for greater integration of health and care services as a driver of prevention, and for standardised monitoring processes/ measures to be introduced. The research appears to also demonstrate an appetite for new resources to help providers with prevention activities, although it seems probable that resources already available in the public domain, were awareness/usage of them to be greater, would go at some least some way to satisfying this demand.

1. About this report

1.1 Introduction

This is a report of findings from an independent research study into prevention in the adult social care sector in England. Undertaken between March and October 2019, the study was commissioned by Skills for Care and was carried out by a team of researchers from York Consulting LLP. The research involved consultation with commissioners of adult social care services and adult social care providers.

1.2 Aims and objectives

The overarching aim of the research was to strengthen the evidence base that exists on the following topics:

- Social care providers' definitions and understanding of prevention in adult social care;
- Social care providers' views on the importance of prevention and the ease or difficulty with which prevention activities can be implemented in practice;
- The impacts of prevention activity on people who access care and support services, employees working in the sector and adult social care providers;
- Commissioners' views on prevention;
- The implications of the prevention agenda for workforce development.

1.3 Research method

Explained below, the study has involved four stages of primary research activity. The research tools used during the study are supplied at Appendix A.

Stage 1: Initial provider consultations

Between May and July 2019, one-to-one qualitative consultations were undertaken with 15 adult social care providers. The providers put themselves forward to take part in the research having been made aware of the opportunity via Skills for Care's network of regional managers. The 15 providers comprised eight adult residential care providers (with or without nursing) and seven domiciliary care providers.

The Stage 1 consultations provided useful early insight into how providers define prevention and embed it in the delivery of their care and support services. In doing so, they also informed the design of the research tools used in Stages 2 and 3.

Stage 2: Provider telephone survey

The purpose of this stage was to gather a large, robust body of evidence on prevention from providers working in adult social care. It comprised a quantitative telephone

survey, undertaken between July and October 2019, mainly using closed questions with Likert-style[1] responses options.

The original intention was to stratify the survey sample by the following variables:

- Service area (domiciliary, residential etc.);
- Care Quality Commission (CQC) rating;
- Region;
- Organisation size.

Contact details for providers were obtained from the CQC's care directory. In practice, it proved difficult to achieve the target number of interviews whilst also stratifying on each of the variables above. The main reason for this was that the survey essentially constituted 'cold calling', in that the providers had no prior knowledge of the research. Midway through the survey, the decision was therefore taken to stratify only on service area, the aim being to achieve a broadly even split between residential and non-residential care providers. The composition of the final sample was 53% residential providers and 47% non-residential care providers. This broadly reflects the composition of the sector nationally, where 49% of care providing establishments are residential and 51% are non-residential care providers.

Stage 3: Follow-up provider consultations

One-to-one qualitative consultations were undertaken by telephone with 15 social care providers who agreed to discuss their survey responses in more detail with the researchers. The aim of the consultations was to explore emerging issues and themes from the provider telephone survey in greater depth. Eight residential and seven domiciliary providers took part.

Stage 4: Commissioner forum

In August 2019, the researchers ran an online consultation exercise with commissioners from 11 different English local authorities. Commissioners took part voluntarily having been invited via Skills for Care's area networks. Invitees included representatives from Clinical Commissioning Groups (CCGs), local authorities, public health and integrated health and social care services.

The consultation ran for two weeks and included ten questions on current and future approaches to prevention from the perspective of commissioners/local authorities. Questions were posted on the online discussion forum by the research team. Commissioners were able to respond directly to those questions, could reply to comments made by other commissioners and could pose additional questions.

[1] A scale used to represent people's attitudes on a topic.

1.4 Composition of the provider telephone survey sample

Just over half (53%) of the 302 providers who took part in the telephone survey were residential providers (with or without nursing), while 37% provide domiciliary care (Table 1.1). The final split was therefore 53% residential and 47% non-residential. This broadly reflects the composition of the sector, where 49% of care providing establishments are residential and 51% are non-residential care providers.

Table 1.1: Main service area

	No. providers	% Providers	% Sector
Adult residential and/or nursing care	159	53%	49%
Adult domiciliary care	111	37%	43%
Supported living	25	8%	7%
Adult community care	3	1%	1%
Other	4	1%	-
Source: Social care provider survey (n=302).			

Just over three quarters (76%) of the providers operate in the private sector (Table 1.2). Far smaller proportions represented local authorities, voluntary/third sector or other organisation types.

Table 1.2: Organisation type

	No. Providers	% Providers
Private sector	231	76%
Local authority	30	10%
Voluntary or third sector	28	9%
Other	13	5%
Source: Social care provider survey (n=302).		

Just under three-quarters (72%) of the providers who contributed to the research represent organisations with fewer than 50 employees. This compares with 86% nationally (Table 1.3)[2].

[2] It is likely that some employers provided an answer to this question in relation to the size of their establishment, rather than their organisation as a whole. For example, 26 (of the 30) employers who gave their establishment type as local authority said that their organisation had less than 250 employees.

Table 1.3: Number of employees			
	No. Providers	% Providers	% Sector
1-49	218	72%	86%
50-99	50	17%	8%
100-249	18	6%	4%
250+	12	4%	2%
Don't know	4	1%	-
Source: Skills for Care (2019): 'State of the adult social care sector and workforce in England' and provider survey (n=302).			

Input was received from social care providers in each region of England (Table 1.4). This broadly reflects the regional distribution of providers across England.

Table 1.4: Region			
	No. providers	% Providers	% Sector
South East	50	17%	17%
North West	39	13%	12%
South West	40	13%	12%
East Midlands	36	12%	9%
West Midlands	36	12%	10%
London	37	12%	15%
Yorkshire and Humber	30	10%	9%
East of England	24	8%	11%
North East	10	3%	5%
Source: Skills for Care (2019): 'State of the adult social care sector and workforce in England' and social care provider survey (n=302).			

1.5 Cross-tabulation

The analysis underpinning this report has included cross-tabulation by a range of variables, including service area, organisation size and location. If no such differences are mentioned in the presentation of the results that follows, it should be assumed that either the cross-tabulations revealed no substantial differences or that the sub-group samples were of an insufficient size. A breakdown of results by residential and non-residential care providers is provided in Appendix B.

1.6 Acknowledgements

The researchers would like to place on record their thanks to everyone that has contributed to this study. Thanks are also owed to the Skills for Care team for their ongoing help and support.

2. Defining prevention in adult social care

2.1 Social care providers' definitions

Investigating social care providers' definitions of prevention was a key theme of Stage 1. Whilst not necessarily representative of the sector as a whole, this provided valuable insight into the different thinking that exists on this topic. Although providers' feedback was varied, four main themes or sub-definitions emerged:

- Helping those who access care and support to live as healthily as possible both mentally and physically;
- Helping to reduce the use of health services, including primary care, emergency services and hospitals;
- Preventing or reducing the escalation of health issues;
- Supporting people to remain as independent as possible.

> *"At a basic level, prevention is about acting in the best interests of residents and moving quickly to stop things escalating. It is about being proactive rather than reactive."* Residential care provider

Five providers also said that supporting their own workforce falls within their definition of prevention (this is a notable departure from the telephone survey findings, where almost 90% cited staff-facing prevention activity). Examples included promoting good mental and physical health, reducing stress and burnout and promoting a good work-life balance.

The providers were unanimous in their view that prevention is not a standalone task or activity, but is interwoven within business-as-usual delivery. This view is shared by the majority of the providers surveyed by telephone, three quarters of whom said that social care, by its very nature, has a prevention focus. Equally evident in the provider feedback was the view that prevention is central to the provision of high-quality care and support.

2.2 Policy agenda

Providers and commissioners were in broad agreement that prevention is evident within adult social care policy at a national level:

- Nearly three-fifths (57%) of the providers surveyed by telephone said there is a clear policy direction, while 69% said they understand the key facets of current policy;

- All 11 commissioners who took part in the research said that, in their view, prevention policy is well defined and the requisite leadership is in place within their organisations to ensure it is taken forward effectively.

In addition, providers are aware of, and understand, Government policy documents that include plans to promote collaboration between health and social care (e.g. the NHS 10-year plan). They are also aware of prevention policy relevant to their local area, although their awareness of policy documents that are more prevention-specific is more limited. For example, only seven of the 30 providers said they were aware of, and understood, the Department of Health and Social Care's 'Prevention is better than cure' and Public Health England's 'From evidence into action' documents. Almost all providers said that, in their view, information and guidance on how to translate prevention policy into on-the-ground delivery is relatively limited.

Commissioners expressed a shared view that the prevention agenda is intrinsically linked to plans for greater integration between health and social care. They cited examples of prevention strategies being co-produced and implemented across health and social care as evidence of this.

2.3 Current prevention activity

There is broad agreement amongst providers that prevention features in their organisation's policies and/or strategies (91% of providers in the telephone survey said this). Typically, this takes the form of prevention being cited in wider or more general policies (e.g. health and safety or safeguarding) rather than there being standalone, prevention-specific documents.

There was equally strong agreement amongst providers that prevention is embedded within the everyday activities of their staff and that it is seen as an integral component of their care and support services. This is reflected in Table 2.1, which shows that high proportions of the providers said that at least one (and usually many) of the prevention-related activities covered by the survey are commonplace in their establishment.

There is clearly a degree of inter-relation across these categories, especially those that reference physical health, diet, lifestyle and self-care. It is also of some note that 89% of the providers said they provide support for their own staff on mental health and wellbeing and that they would class that as prevention. In addition, 87% of providers said that prevention is a focus for workforce development within their organisation.

Given that prevention activity closely aligns with the nationally-led agenda to integrate health and social care services, it is encouraging that 89% report having close working relationships with colleagues in other sectors – the main one being health.

Differences in prevention activity by main service area are denoted by the cell shading in the table. Purple indicates that more residential providers have that activity in place. Orange indicates more non-residential providers. In summary:

- Residential providers are more likely than their non-residential counterparts to have activity in place to support the physical and mental health of people accessing care and support. For example, exercise and movement plans.
- Non-residential providers are more likely than residential providers to have links with other services (e.g. colleagues working in other sectors and social prescribing services). Non-residential providers are also more likely to have prevention activity to support their staff in place.

Table 2.1: Current prevention activity			
	% residential providers	% non-residential providers	% all providers
Monitoring and tracking of physical health concerns	94%	89%	92%[3]
Close working relationships with colleagues in other sectors	88%	92%	89%
Support for staff mental health and wellbeing	84%	95%	89%*
Procedures to provide people accessing care and support with advice and guidance to promote healthy lifestyles	86%	89%	88%
Support for the diet, hydration and nutrition of people accessing care and support	87%	79%	82%*
Support for the mental health and wellbeing of people accessing care and support	87%	78%	82%*
Exercise and movement plans to promote physical health	86%	67%	78%*
Proactive procedures to promote self-care and self-management amongst people accessing care and support	79%	81%	78%
Activity focussed on Making Every Contact Count	71%	82%	76%*
Support for staff to advise on physical health, diet, nutrition, exercise etc.	64%	71%	67%
Links with social prescribing services	56%	66%	62%*
Falls prevention	65%	60%	60%

Source: Social care provider survey (n=302). Respondents could select multiple answers.

* denotes that significance testing has resulted in a p value of less than 0.05.

[3] Of the 24 employers who said that they do not monitor or track physical health concerns, ten were domiciliary care providers, nine were residential (with or without nursing) care providers, two were community care providers and two were supported living providers. None of these 24 employers agreed to a follow-up consultation so the research has not been able to explore the reasons for these responses.

Monitoring and tracking of health concerns

A manager at a residential provider uses an electronic data dashboard to track a number of variables about residents' physical health. This includes the falls each resident has had and the amount of food and water they have consumed. The information is analysed to help the provider develop a better understanding of individual residents and to put in place appropriate prevention-related measures to support them.

Activity co-ordinator

A residential care provider for people with dementia has a dedicated activity lead within their lifestyle and development team. The role of the activity lead is to ensure that a range of activities are in place for residents, including art therapy, cooking and a variety of physical activities. The rationale for this role is to ensure that supporting the mental and physical wellbeing of residents is a top priority.

Staff training and development

A residential care provider gives employees a range of training opportunities around specific health conditions and taking a strengths-based, motivational approach when interacting with those who access care and support services. The early identification of health problems and prevention are also incorporated within the induction procedures for new staff.

The same provider also has 'prevention champions', each focussing on specific areas (e.g. dental, nutrition etc.). The champions' role is to cascade and embed good practice across the organisation.

Mental health support for staff

A residential care provider has a range of support options in place to help employees with their mental health. These include:

- Mental health champions;
- Employee assistance programmes[4];
- Support to deal with difficult events, e.g. where someone accessing care and support dies or becomes seriously ill.

[4] These confidential, external helplines provide a range of support for employees, for example counselling.

Health and wellbeing monitoring

A domiciliary care provider works with a local GP practice to monitor the physical and mental health of the people for whom they provide care and support through bi-annual health and wellbeing checks. The aim is to ensure the early identification of health issues and to prevent them from escalating. The GP practice also undertakes regular reviews of the medication prescribed to the people accessing care and support through the care provider.

Exercise and movement plans

A domiciliary care provider creates an exercise and movement plan for those accessing care and support who have just left hospital. Staff also provide guidance on helpful exercises, how to exercise safely and the benefits of doing so. The aim is to increase mobility, prevent falls and help with reablement.

Making Every Contact Count

A domiciliary care provider has embedded a Making Every Contact Count approach within their organisation. This has included staff training to ensure they have the skills and confidence to engage people who receive care and support in improving their physical and mental health.

Tools and resources from the National Institute for Health and Care Excellence and Public Health England, for example assessment tools to check service provision is in line with guidelines, have also been utilised throughout the organisation to embed the approach.

2.3.1 Commissioners' views

Commissioners were asked to list the services they commission that they would categorise as 'prevention'. As shown in Table 2.2, their responses fell into two categories.

Table 2.2: Prevention services	
Type of support	**Examples of services**
Independent living support services	- Carer support services - Reablement support, including assistive technology and home improvement - Day centres
Health and wellbeing services	- Social prescribing services - Community navigators - Mental health support services

However, commissioners were also clear in their view that prevention activity is not happening simply or solely because it features within commissioning specifications. That obviously plays a part, but they shared providers' views that, in practice, prevention is (or should be) integrated within day-to-day delivery of care and support and not something that is separate or isolated from it.

Community neighbourhood link workers

Link workers are a team within a local authority who can:

- Provide advice and support around accessing local activities and services;
- Support people accessing care and support on a one-to-one basis to help build confidence and self-esteem;
- Provide support around completing paperwork and forms (e.g. to help in accessing benefits).

The aim of this service is to maintain (or improve) the mental health and wellbeing of people accessing care and support within the community.

Help after leaving hospital

One local authority has a service run in partnership with the Clinical Commissioning Group and Age UK. The service supports those with low to moderate social care needs to leave hospital where delays are being caused by domestic arrangements. The types of assistance it offers include:

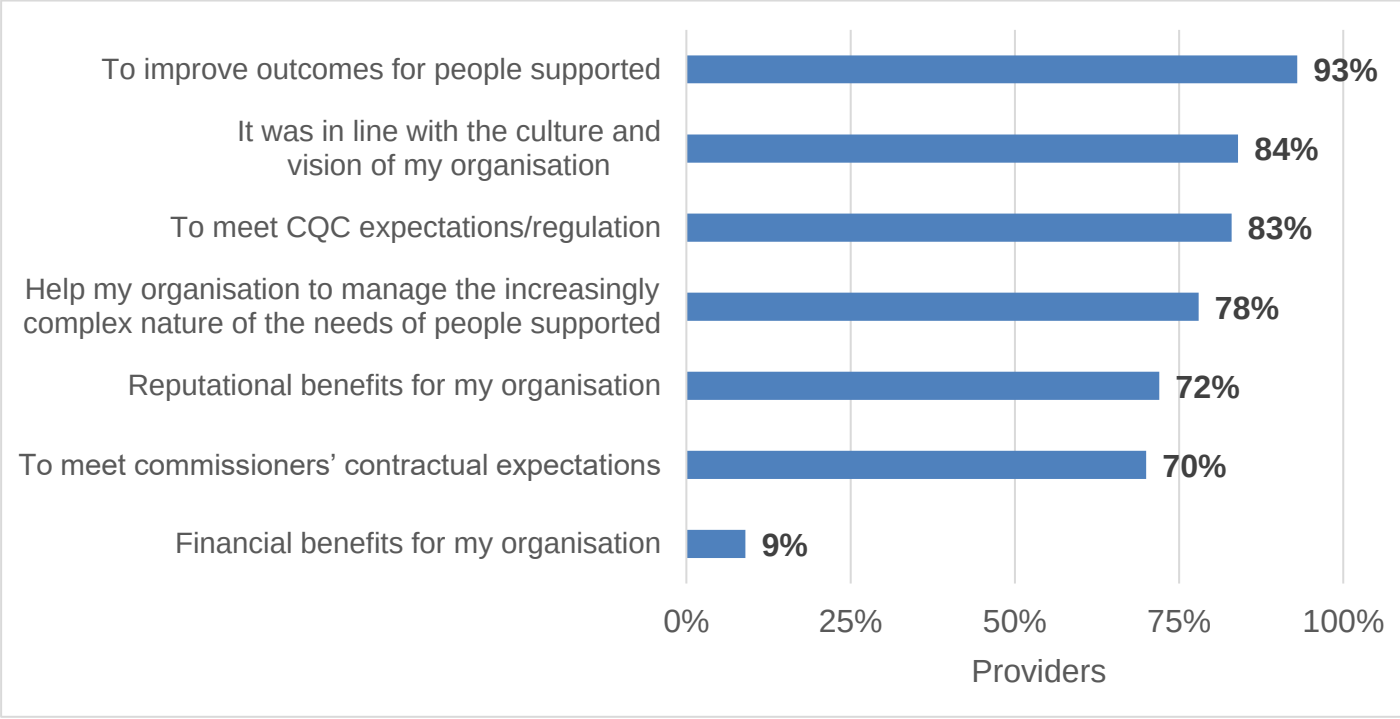
- Ensuring there is food in the house and the heating works correctly;
- Providing advice on self-care and self-management;
- Helping to re-build self-confidence;
- Signposting to other services (e.g. falls prevention and sensory teams).

3. Rationale and implementation

3.1 Rationale for prevention activity

There are several key reasons why providers have implemented prevention-related activities, the most regularly cited of which was that it will help to improve outcomes for the people for whom they provide care and support (as shown in Figure 3.1, 93% of surveyed providers said this). High proportions of providers also said that prevention was in line with the culture and vision of the organisation (84%), that they were doing so with CQC inspections in mind (83%) and/or that it would help them to manage complex needs (78%). There were no substantial differences in the proportions of residential and non-residential care providers citing these reasons as motivations.

Figure 3.1: Rationale for implementing prevention activity



Source: Social care provider survey (n=302). Totals sum to more than 100% as respondents could select multiple answers.

"Clients have increasingly complex needs and we need to be able to cope with that. We also want to do our best by them – we want them to have a good quality of life." Residential care provider

"I think we are a very preventative provider – I would say the prevention work fits with our ethos and culture." Residential care provider

3.2 Implementing prevention activity

Table 3.1 summarises providers' views on the factors that have either helped or constrained their implementation of prevention-related activity.

The summary is that most of the factors covered by the survey are seen to have helped. That is especially true of leadership, the knowledge, attitudes and behaviours of staff, relationships with the families of the people they support and partnership working with colleagues in other sectors. Against each of these categories, more than half of the providers in the sample gave a response of 'helped'.

Views were more mixed on support, guidance and resources related to prevention (a topic we return to later). Time pressures and financial resources – so often amongst the most significant challenges within adult social care – were flagged as constraining factors with the greatest regularity in the survey.

In terms of differences by main service area, non-residential care providers are more likely than residential providers to cite factors covered by the survey as constraining their implementation and/or delivery of prevention activity. The italics in the table denote those categories with non-residential care providers were more likely than their residential care counterparts to cite the statements as constraints. Across the other statements there was no substantial difference.

Table 3.1: Implementing prevention activity				
	Helped	**Constrained**	**Neither helped nor constrained**	**Don't know**
Leadership within my organisation	70%	6%	23%	1%
Knowledge, attitudes and behaviour of staff	62%	12%	24%	2%
Relationships with the families of people supported	55%	7%	36%	2%
Partnership working with colleagues in other sectors	54%	7%	37%	2%
Availability and access to local community facilities	*49%*	*19%*	*29%*	*3%*
CQC expectations/regulation	46%	12%	39%	3%
Support, guidance or training resources	46%	5%	46%	3%
Use of technology within my organisation	44%	10%	43%	3%
Size of my organisation or setting	35%	8%	52%	5%
Amount of staff time available to deliver prevention activity	*29%*	*34%*	*33%*	*4%*
Ability to recruit and/or retain staff	*23%*	*29%*	*44%*	*4%*
Financial resources	15%	47%	33%	5%
Source: Social care provider survey (n=302).				

In terms of why the figures in the table look as they do:

- **Staffing:** having staff that are willing to adapt and engage with new ways of working is very beneficial to the implementation of prevention. Likewise having staff that are experienced and who understand and support the organisation's culture and ethos.
- **Financial resources:** commissioners agree with providers about financial resources being the most significant challenge.
- **Partnership working:** particularly important are the relationships that social care staff have forged with hospital discharge teams, reablement teams and those working in primary care. This has enabled them to quickly share information and make co-ordinated decisions about care and support needs, although agreeing information sharing protocols and establishing channels of communication are not always without challenge.
- **Resources:** providers cited the Skills for Care, NHS Choices and the CQC websites as being useful sources of prevention-related information, although the results would seem to indicate that awareness of the resources available on all three of these could be higher.

"You need to have staff that are skilled, competent and who share your vision for the business. You cannot underestimate the importance of having to good team in place when bringing in new initiatives." Domiciliary care provider

"Working with NHS services e.g. hospital discharge teams can be very difficult. It is hard to get in and see them to have that initial conversation. You really need them on your side though to do a lot of it [prevention activity]." Residential care provider

"The [CQC] provider portal is really useful – there are lots of case studies around it [prevention] and I find the information clear and easy to use. They don't just inspect they are a useful source of information." Residential care provider

4. Impacts of prevention activity

4.1 Impacts of prevention activity

Providers are very positive about how their prevention activity has helped them to achieve better outcomes for individuals accessing care and support (as shown in Table 4.1, 85% of those surveyed cited this as a positive impact of prevention). When asked how/why this had happened, they typically said their prevention activity had enabled them to:

- Be more responsive to individuals' health needs;
- Provide more tailored and personalised care;
- Identify problems earlier and prevent escalation;
- Reduce the need for emergency health services and hospital admissions;
- Promote independent living and reduce social isolation.

Within the qualitative consultation sample, providers also reported that prevention is causing levels of satisfaction amongst recipients of the care and their families to increase.

Also of note from Table 4.1 is that:

- Almost three quarters of providers said that prevention had helped them to deliver their organisation's aims (73%), that it had improved their employee's self-awareness regarding their own health (73%) and/or that it had increased levels of job satisfaction (72%). Providers typically linked the job satisfaction improvements to staff feeling happier and more motivated because of the benefits they're observing amongst people who access care and support (a virtuous circle effect).
- Just under two thirds of providers (65%) said that prevention had resulted in staff being offered new or additional training opportunities. Examples included training for staff to deliver physical activity sessions, to recognise signs of poor health and to offer advice and guidance on self-care.
- 41% of providers said that their prevention activities had been beneficial in terms of staff recruitment and/or retention. Whilst this is a minority of the total sample, the prevalence of recruitment and retention challenges within the sector mean it is nonetheless a very encouraging outcome.
- It was very rare for providers to say that prevention had resulted in negative consequences for them. Fewer than one in ten did so against any of the categories in the survey.

Note that the italics in the table denote those categories where non-residential care providers were more likely than their residential care counterparts to cite a positive impact. In the other categories there was no substantial difference.

Table 4.1: Impacts of prevention activity

	Positive impact	Negative impact	No impact	Don't know
Achieving better outcomes for those accessing care and support	85%	-	8%	7%
Delivery of my organisation's vision/aims	73%	-	21%	6%
Staff awareness and knowledge about their own health and wellbeing	73%	3%	20%	4%
Levels of job satisfaction	72%	3%	21%	4%
Profile, awareness and reputation of my organisation	*68%*	*1%*	*22%*	*9%**
Training opportunities	*65%*	*1%*	*31%*	*3%**
Levels of staff recruitment and/or retention	41%	7%	46%	6%
Employee stress and burnout	*35%*	*7%*	*48%*	*10%**

Source: Social care provider survey (n=302).

* denotes that significance testing has resulted in a p value of less than 0.05.

"I would say it has enhanced our quality of care. The feedback we are getting from clients and their loved ones shows us they are happy with the work we are doing." Domiciliary care provider

"Our prevention work has given some residents a new lease of life. They are happier and more stimulated." Residential care provider

"Staff are happier when clients are more settled and happier – it makes their job easier." Domiciliary care provider

4.2 Measuring impact

Providers were clear in their views about the positive impacts of their prevention activities, although an equally clear finding is that they are not monitoring or measuring those impacts formally or systematically. There are two main and understandable reasons for this:

- Many providers do not have either the time or the knowledge required to formally/objectively assess the impacts of individual aspects of their care and support offer.
- Even if they did, the fact that prevention is consistently reported to be interwoven within the day-to-day delivery of care and support would make it difficult to isolate its impact.

"I find many of the outcomes are not 'measurable' through statistics and so we do case studies and surveys to determine positive or negative feedback instead." Domiciliary care provider

Commissioners appear more likely to try and assess the impact of specific prevention activities, namely those relating to reablement and healthy lifestyle services. However, they too spoke candidly about the difficulties of doing so authoritatively, particularly in terms of:

- Selecting appropriate indicators;
- Collecting (the right) quantitative data;
- Comparing results across different services;
- Attributing impacts to a specific intervention as distinct from care packages as a whole.

"Measuring the impact of preventative activities is often a challenge – especially attaching a cost avoidance/saving to them." Local authority commissioner

"The issue in a nutshell is: how do you measure something which hasn't happened (and may not have happened anyway) and then directly attribute that to the services?" Local authority commissioner

5. Commissioning and prevention

5.1 Views of providers

Just under three-quarters (72%) of providers said they believe prevention to be a focus for local commissioners (19% were unsure and 9% said they don't think it is a focus). Views were more mixed on how the priorities of local commissioners had impacted on the implementation of providers' prevention activities:

- 49% of providers said that the priorities of local commissioners had neither helped nor hindered their ability to implement prevention activity;
- 20% of providers said the priorities had helped them;
- 19% (and domiciliary care providers in particular) said the priorities had acted as a constraint;
- 14% of providers were unsure.

It is likely that the 49% of providers in the bullet point above is influenced, to some extent at least, by them being unsure about their commissioners' specific expectations around prevention. Providers regularly remarked that:

- Communications on this topic have, in their view, sometimes been rather sporadic and unclear;
- They have had only limited opportunities to ask questions of commissioners about prevention and to seek clarification around their expectations;
- They would like more clarity on commissioners' expectations for prevention in future specifications.

Views of commissioners

The commissioners contributing to the research were in shared agreement about prevention being formally included within commissioning specifications and commissioned services. In summary:

- There are some services (e.g. health and wellbeing services and independent living support services) that commissioners describe as 'prevention' services and are commissioned specifically with prevention in mind (see 'Commissioners' views' in Chapter 2);
- Prevention is nonetheless becoming more prevalent (or more overt) across commissioning specifications for all care provision, although it is not yet universal or consistent;
- Over time, the commissioners would expect it to feature overtly within all specifications;

- Despite the work-in-progress position at the time of writing, commissioners were clear that whilst prevention may not be overtly mentioned in the specifications for all activities to which it is relevant, they would nonetheless expect it to feature heavily in delivery. They spoke, for example, of contracts with care providers referencing strengths-based approaches, the importance of self-care and co-production[5], all of which have direct links to prevention.

Co-production is of particular note here, especially as the 2014 Care Act states that, *"in developing and delivering preventative approaches to care and support, local authorities should ensure that individuals are not seen as passive recipients of support services, but are able to design care and support based around achievement of their goals"*. The commissioners taking part in the research agreed unanimously that co-production has an important role in commissioning for prevention. They also shared the view that, in their local areas, local communities are being given the opportunity to contribute to commissioning processes. Examples include:

- Tender review panels;
- Contributing to the design of new services;
- Attending cabinet meetings;
- Citizens' assemblies.

"Co-production is a key element in the shaping of our strategies and commissioning intentions. We have a range of partnership boards that we are able to consult with."
Local authority commissioner

However, barriers to effective co-production were also identified, including:

- **Representation:** it can be difficult to ensure that a broad/representative range of residents from the local community are engaged in co-production processes. Commissioners report that this can be a particular issue in rural and disadvantaged areas.
- **Purposeful engagement:** commissioners remarked how, if not afforded the requisite time and resource input, co-production can be – or can be seen within the local community as being – little more than a procedural or tick-box exercise.
- **Time and resources:** commissioning activities can often run to tight timescales, constraining co-production opportunities and increasing the risk of community disengagement. It can also be a challenge for local authorities – given the severe financial constraints within which social care departments have been obliged to function in recent years – to commit financial resources to co-production on a scale that maximises its effectiveness.

[5] A way of working whereby the local population and decision makers, or people who use services, family carers and service providers work together to create a decision or service which works for them all. The approach is value driven and built on the principle that those who use a service are best placed to help design it.

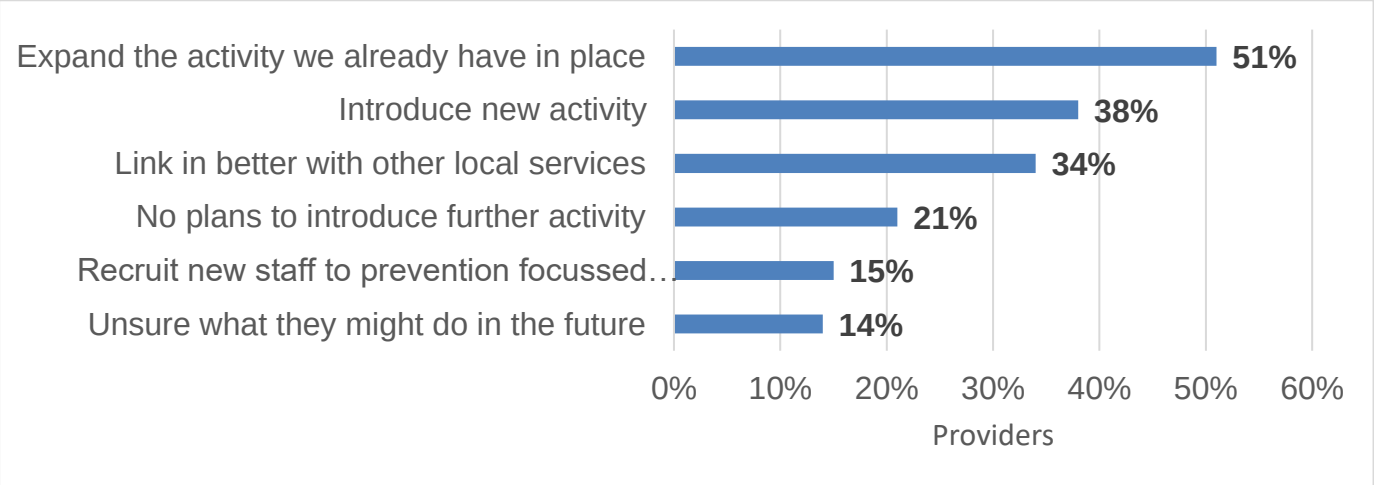
6. Looking ahead

6.1 Providers' plans

Prevention activities are by no means static or steady-state amongst the providers in the research sample. For example, and as shown in Figure 6.1 (and noting that there were no substantial differences between residential and non-residential providers):

- More than half (51%) intend to increase the scale and/or reach of their current prevention activity;
- Nearly two-fifths (38%) intend to introduce new prevention activities (examples are provided beneath the table);
- More than a third (34%) plan to develop stronger/better links with providers of other local services, including those offering reablement and social prescribing;
- Only one in five providers (21%) said they had no plans to do anything else/ differently on prevention.

Figure 6.1: Plans for future prevention activity



Sources: Social care provider survey (n=302). Respondents could select multiple answers.

6.1.1 New activities

Most of the providers who said they intend to introduce new prevention-related activities were unable to provide further detail on what those activities are likely to involve. The few that did spoke of:

- **Supporting the mental health and wellbeing of staff:** including new mentoring arrangements and new training on mental health.
- **Making more effective use of technology:** in particular, adopting electronic recordkeeping in order to better analyse, pre-empt and respond to the needs and issues of people who receive care and support.

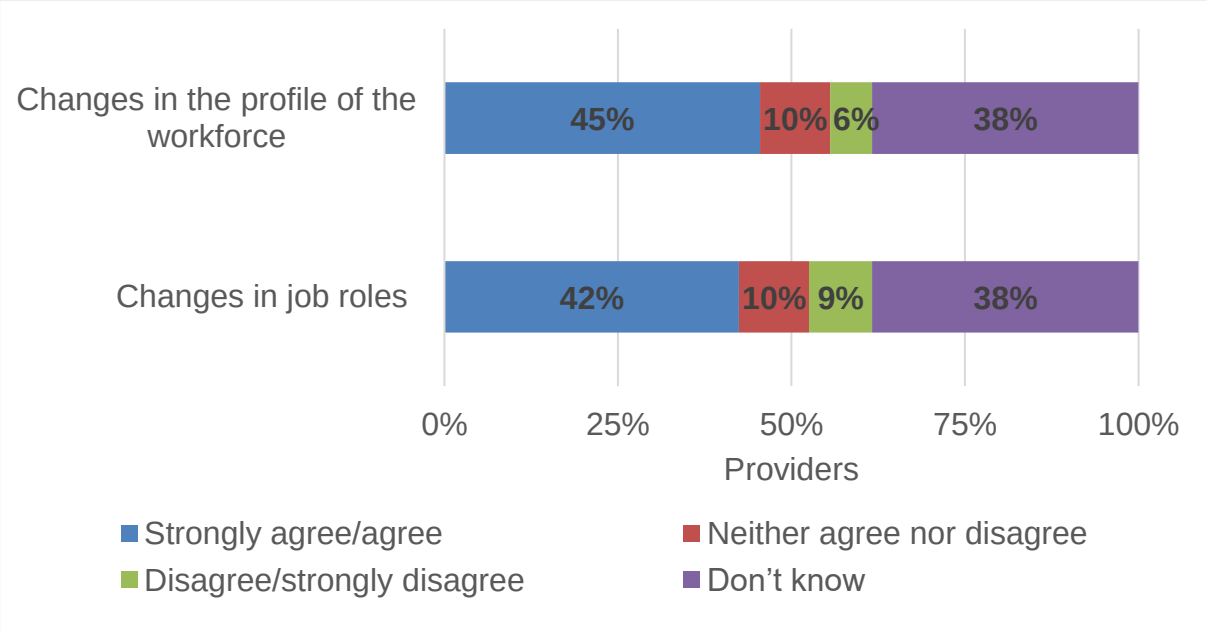
- **Local engagement:** redoubling efforts to develop relationships with local voluntary and community-based organisations (including charities and schools) to increase the range of activities available to those who receive care and support.

6.1.2 Workforce development

Fifteen percent of providers said they plan to recruit new staff into prevention-focussed roles. Examples included activity workers, specialist co-ordinators (including those with expertise in dementia and mental health) and care liaison officers.

All of the providers were also asked whether they expect job roles and/or the composition of the adult social care workforce to change as a result of prevention activity. Just over a two-fifths agreed in both cases, although similar proportions were unsure (Figure 6.2). The qualitative consultations showed there to be considerable uncertainty about what any change may look like, even amongst those who are predicting change to occur. There were no substantial differences in the views of residential and non-residential providers.

Figure 6.2: Future impacts on workforce development



Source: Social care provider survey (n=302).

6.2 Support to help with future prevention activity

There is a strong and clear message from the research (and from both residential and non-residential providers) that changes introduced at a national level could help them to implement and deliver more prevention activity and to do so with greater impact. For example, and as shown in Table 6.1:

- Almost all providers would advocate greater integration of health and social care services (a view echoed by the commissioners and explained in more detail below the table);
- Almost nine in ten would welcome more support, guidance and/or training on prevention-related topics and activities;
- More than 80% would like to see standardised monitoring for prevention, while two-thirds would like prevention to be more prevalent in the inspection work of the CQC.

Table 6.1: National changes recommended by providers	
	% of providers
There needs to be greater integration of health and social care in order to maximise the benefits of prevention activity.	96%
More support, guidance and training is needed for social care providers to help them deliver prevention activity.	87%
There needs to be a standardised process of monitoring prevention outcomes across providers in the sector.	84%
There should be a greater focus on prevention within CQC inspections.	66%
Source: Social care provider survey (n=302).	

The qualitative consultations shed further light on the first two of the four topics above:

- **Integration:** providers hope that closer integration will further improve co-ordination of care and speed of access to support. Recommendations included multi-disciplinary delivery of specific prevention services (e.g. social prescribing) and employees in social care performing a wider range of tasks usually undertaken by healthcare professionals, such as blood tests.
- **Support and guidance:** an array of prevention-related resources already exist, including, although by no means limited to, Health Education England's 'Population health and prevention' web portal, Making Every Contact Count resources, Skills for Care's Learn from Others website, the 'All our health' e-learning hub and the Population Wellbeing portal. It is therefore quite possible that the real issue is not that more resources are needed, but that providers would benefit from being more aware of those that already exist. Related to this is the fact that providers could only rarely specify the topics that they would like new resources to cover. Where they could, their suggestions included:
    - A guidance document succinctly explaining key messages from the policy agenda and ideas on how these can be incorporated within operational delivery;

- Training materials and tools focused on key aspects of prevention, such as exercise plans and falls prevention;
- Case studies showcasing prevention ‘good practice’ from providers in the sector;
- Top tips on establishing links with colleagues in other sectors, particularly health;
- An online forum to enable providers to consult each other about prevention activity;
- A central repository of prevention training materials and guidance documents.

7. Conclusions

This research provides up to date evidence from providers and commissioners on prevention in adult social care. Perhaps predictably, it has found that prevention does not have a single or homogenous definition, although there are several themes with which most of the providers and commissioners in the research sample would identify. There are also several areas or types of prevention-related practice that appear commonplace, though differences in type of provision cited by residential and non-resident providers exist. Residential providers are more likely to have activity in place to support the physical and mental health of people accessing care and support, whereas non-residential providers are more likely to have links with other services and support for their staff.

Importantly, the research has revealed unanimous agreement that whilst prevention is often positioned as a standalone topic, in practice it is quite the opposite. Instead, it exists as an integral component of the day-to-day delivery of high-quality care and support. It is not the responsibility of one person or a dedicated team with care providers, but is an expectation that is increasingly being placed on staff at all levels.

The key enablers of effective prevention are the same as those that drive effective practice in the sector more broadly. They include leadership, staff knowledge and skills, effective communication and strong working relationships with colleagues working in other parts of the health and care system. As is so often the case, the dual pressures of time and financial resources combine to prevent some providers from being as innovative and all-encompassing with prevention as they would like. Non-residential providers in particular cite factors as constraining their implementation and delivery of prevention activity.

The research suggests that when prevention activities are implemented well, they deliver positive results. Care and support packages become more tailored, satisfaction with those packages increases, health issues do not escalate as quickly and employee morale can improve. That said, there is currently very few formal or systematic impact assessments undertaken on prevention activities and the feedback gathered through this research, whilst often effusive and very positive, must be seen in that context.

The research appears to demonstrate an appetite amongst providers (both residential and non-residential) for new resources to help them further implement and embed prevention activities. However, this appetite tends not to be accompanied by specific or detailed requests regarding the topics or activities that the new resources should cover. Although not proven categorically through the research, it seems likely that the resources are already available in the public domain – the number and breadth of which should not be understated – would, if accessed by more providers, satisfy at least some of the requests that are being made for new material.

Despite its prevalence, prevention activity remains a work in progress in adult social care. It is becoming more prominent in commissioning specifications but there is more to do for that to become universal and consistent. Providers can lack clarity on commissioners' priorities for prevention and co-production involving prevention activities/themes is not without its challenges. Encouragingly though, the direction of travel appears positive: the general trend is for providers to be planning more or different prevention activities rather than just maintaining the status quo.

Appendix A: Research tools

Stage One: Initial Provider Consultations

Section One: Background

1. **Establish:**
   a. Job role of interviewee
   b. Key characteristics of establishment (e.g. location, number of employees, service area, service type(s), client group and age range)

Section Two: Understanding and awareness of the prevention agenda

2. **How would you define 'prevention' within the context of adult social care?**

   Probe:

   Are there other terms you (or others) use to describe prevention-type activity?

3. **What is your understanding of the current and future health and social care policy direction for prevention?**

   Probes:

   For example, NHS 'Long Term Plan', PHE 'From Evidence into Action', DHSC 'Prevention is Better than Cure', All Our Health Programme, future Prevention Green Paper

   Do you think there is currently strategic vision and drive for the prevention agenda within the adult social care sector?

   Do you think your understanding of current and future policy is sufficient?

Section Three: Current and future prevention activity

4. **Please tell us about activity under the prevention agenda that is currently being undertaken within your organisation.**

   Probe for specific examples.

   To what extent is this prevention activity embedded within everyday practice?

   How do you view this prevention activity within the context of everyday roles within social care?

   Do you think your organisation's current prevention activity is sustainable?

5. **[If prevention activity is being undertaken] What was your organisation's rationale for introducing this activity?**

   Probes:

   For example, benefits for clients (e.g. improved service, quality of life), benefits for your organisation (e.g. commercial, reputational)

   Did this activity happen as a result of consideration of the prevention agenda or as a result of business as usual?

   Does prevention feature formally within any of your organisation's policies or strategies?

   Have commissioning decisions impacted on your decision to introduce this activity?

6. **Do you have plans to introduce future prevention activity within your organisation?**

   Probes:

   If yes, please explain what you plan to introduce and why.

   If no, why is this?

Section Four: Implementation and delivery of prevention activity

7. **Are there any success factors you think may help organisations implement and/or deliver prevention activity?**

   Probes:

   Why do you think these are important?

   Do you think characteristics (e.g. size, service area) of organisations are a factor?

8. **Do you think there are any constraints and/or challenges to delivering activity under the prevention agenda?**

   Probe:

   How easy and realistic do you think it is to embed prevention activity within the everyday job roles of your workforce?

9. **[If constraints/barriers exist] Is there anything currently in place, or that could be put in place in the future, to overcome these constraints and/or challenges?**

   Probe for specific examples.

10. **Have you accessed any support or training (e.g. All Our Health e-learning or Population Health Portal e-learning, other resources and guidance) to help you deliver and/or consider delivering prevention activity within your organisation?**

    Probes:

    How useful did you find the support or training you accessed?

    Is there any additional support you feel would be beneficial?

Section Five: Outcomes and Impacts

11. **What have, or could be, the impacts (either positive or negative) of delivering prevention activity on:**
    a. **Your organisation?**
    b. **Your workforce?**
    c. **Your clients?**
    d. **Partnership working within the health and social care sector?**

    Probes:

    Have the impacts you have seen met your expectations?

    Do you think anything could be done to improve the impacts?

12. **What (if any) do you consider to be the implications of the prevention agenda for workforce development?**

    Probe for specific examples.

    Have there, or do you think there might be in the future, changes in job roles and/or the profile of your workforce?

13. **Do you track and/or monitor specific prevention outcomes amongst your organisation's clients?**

    Probes:

    If yes, what are these? How do you measure them?

    What (if any) are commissioners expecting you to measure specific prevention outcomes?

    If outcomes are not measured, why not?

14. **Is there anything else about the prevention agenda or activity you would like to add?**

Stage Two: Provider Telephone Survey

Section One: Understanding and awareness of the prevention agenda

1. **To what extent do you agree or disagree with the following statements?**
   By the prevention agenda, we are referring to key national policy concerning prevention, including the NHS 'Long Term Plan', Public Health England's 'From Evidence into Action', and the Department of Health and Social Care's 'Prevention is Better than Cure'.
   (Ask all and select one per row)

	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**Don't know**
There is a clear policy direction for prevention within the adult social care sector.						
I have a good understanding of the prevention agenda.						
Social care, by its very nature, is about prevention – i.e. it has a focus on delaying and reducing the need for more intensive and higher-cost health and social care.						
My organisation provides services that have been commissioned to deliver prevention activity.						

Section Two: Current and future prevention activity

2. Which (if any) of the following do you currently have in place within your organisation?
(Ask all and select all that apply)

Activity focussed on Making Every Contact Count	
Close working relationships with colleagues in other sectors (e.g. health, housing, emergency services etc.)	Please specify which sectors.
Exercise and movement plans to promote physical activity	
Links with social prescribing services	
Monitoring and tracking of physical health concerns – paper or electronic	
Proactive procedures to promote peoples' self-care and self-management	
Proactive procedures to provide people supported with advice and guidance to promote healthy lifestyles	
Support for peoples' diet, hydration and nutrition	
Support for peoples' mental health and wellbeing	
Support for staff mental health and wellbeing	
Support for staff to advise on physical health, diet, nutrition, exercise etc.	
Falls prevention activity	
Other (please specify)	

3. What was your organisation's rationale for introducing the activity discussed in Question 2?

(Ask all and select all that apply).

Financial benefits for my organisation	
Help my organisation to manage the increasingly complex nature of the needs of people supported	
It was in line with the culture and vision of my organisation	
Reputational benefits for my organisation	
To align with the health and social care policy agenda	
To improve outcomes for people you support	
To meet commissioners' contractual expectations	
To meet Care Quality Commission (CQC) expectations/regulation	
I do not know what the rationale for implementing this activity was	
Other (please specify)	
None of the above	

4. To what extent do you agree or disagree with the following statements?
(Ask all and select one per row)

	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**Don't know**
Prevention activity is embedded within the everyday roles of staff within my organisation.						
Prevention currently features within my organisation's policies and strategies.						
Prevention is a focus for workforce development within my organisation.						
Prevention is a focus for local commissioners.						

5. Which of the following best describes your plans for future prevention activity within your organisation?
(Ask all and select all that apply)

We plan to introduce new activity (please specify).	
We plan to recruit new staff to prevention focussed roles (please specify).	
We plan to link in better to other local services (e.g. care navigators, link workers)	
We plan to expand the activity we already have in place.	
We do not plan to introduce any new activity.	
I am not sure what we plan to do next.	

Section Three: Implementation and delivery of prevention activity

6. In your view, how have the following factors impacted upon your ability to implement and/or deliver prevention activity?

(Ask all and select all that apply).

	Helped	Constraint/challenge	Neither helped nor been a constraint/challenge	Don't know
Ability to recruit and/or retain staff				
Amount of staff time available to deliver prevention activity				
Availability and access to local community facilities				
Care Quality Commission (CQC) expectations/regulation				
Knowledge, attitudes and behaviour of staff				
Leadership within my organisation				
Level of funding				

	Helped	Constraint/challenge	Neither helped nor been a constraint/challenge	Don't know
Partnership working with colleagues (e.g. in health, housing, emergency services etc.)	Please specify which colleagues you are referring to. Please specify how this has helped you.	Please specify which colleagues you are referring to. Please specify why this has been a challenge.		
Priorities of local commissioners – e.g. asset-based commissioning				
Relationships with the families of people supported				
Size of my organisation and/or setting	Please specify whether this is size of setting or organisation.	Please specify whether this is size of setting or organisation.		
Support, guidance or training resources (e.g. All our Health e-learning or Population Health Portal e-learning, other resources and guidance)	Please specify how this has helped you.	Please specify why this has been a challenge.		
Use of technology within my organisation	Please specify how this has helped you.	Please specify why this has been a challenge.		
Other (please specify)				

Section Four: Outcomes and Impacts

What impact has prevention activity on the following?

7. (Ask all and select one per row)

	Positive impact	Negative impact	No impact	Don't know
For your organisation:				
Delivery of my organisation's vision/aims				
Levels of staff recruitment and retention				
Profile/awareness/reputation of my organisation				
For your workforce:				
Employee stress and burnout				
Levels of job satisfaction				
Staff awareness and knowledge about their own health and wellbeing				
Training opportunities				
For the people you support:				
Achieving better outcomes for people you support e.g. • Mental health and wellbeing • Improved physical health • Increased independence • Self-care • Reducing social isolation and loneliness • Better management of health conditions • Reduced or delayed the need for care • Reduction in hospital admissions	Please tell us what the nature of these improvements have been.			

Section Five: Future of prevention activity

8. To what extent do you agree or disagree with the following statements?
(Ask all and select one per row)

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
There should be a change in commissioning to focus more on prevention activities.						
There should be a greater focus on prevention within Care Quality Commission (CQC) inspections.						
There needs to be a standardised process of monitoring prevention outcomes across providers in the sector.						
More support, guidance and training is needed for social care providers to help them deliver prevention activity.						
There needs to be greater integration of health and social care in order to maximise the benefits of prevention activity.						
In the future, there are likely to be changes in job roles within the adult social care sector as a result of prevention activity.	Please specify: - The changes you would expect to see. - Why you would expect to see these changes. - Over what time period would you expect changes to be seen.					
In the future, there are likely to be changes in the profile of the adult social care sector workforce as a result of prevention activity.	As above.					

Section Six: Organisation Details

9. What is your organisation's main service area?

(Ask all and select one)

Adult residential and/or nursing care (please specify)	
Adult domiciliary care	
Supported Living	
Adult day care	
Adult community care	
Other (please specify)	
Don't know	

10. Which of the following best describes your organisation?

(Ask all and select one)

Private sector	
Local authority	
Voluntary or third sector	
Other (please specify)	
Don't know	

11. How many employees does your organisation have in total?

(Ask all and select one)

1-9	
10-24	
25-49	
50-99	
100-149	
150-199	
200-249	
250-499	
500+	
Don't know	

12. Where is the headquarters of your organisation located?
(Ask all and select one)

North West	
North East	
Yorkshire and Humber	
East Midlands	
West Midlands	
East of England	
London	
South East	
South West	
Don't know	

Section Seven: Future Contact

13. Would you be happy for a member of the independent research team, working on behalf of Skills for Care, to contact you to discuss your responses to this survey in more detail?

Yes	
No	

14. If 'yes' to Question 13, please provide/confirm the following details. We will not use your details for any other purpose or share them with a third party without your permission.

Name	
Job Title	
Organisation name	
Street address	
Town	
County	
Postcode	
Telephone number	
e-mail address	

Stage Three: Follow-up Qualitative Consultations with Providers

Section One: Understanding and awareness of the prevention agenda

15. **In relation to your responses to question 1 in the provider survey, please explain:**
    - **a.** Why did you agree/disagree with the statements?
    - **b.** Do you think it would be beneficial to see an increase in the profile and clarity of policy direction for prevention within the adult social care sector?
    - **c.** What (if any) do you think are the barriers and/or constraints to this?
    - **d.** If disagree/strongly disagree that have a good understanding of prevention, to what extent do you consider this to be a problem that needs addressing?
    - **e.** If strongly agree/agree that would like to improve understanding, how do you think this would be best achieved?
16. **In relation to your responses to question 2 in the provider survey, please explain:**
    - **a.** Why did you agree/disagree with the three statements?
    - **b.** What has led you to take this view?
    - **c.** (If appropriate) Do you have any specific examples of commissioning that is currently undertaken to encourage providers to deliver prevention activity?

Section Two: Current and future prevention activity

17. **Please tell us more about activity under the prevention agenda that is currently being undertaken within your organisation.**

    Probe for depth on responses to question 3 in the provider survey.

18. **Please tell us more about the rationale for introducing this activity.**

    Probe for why certain options within question 5 were motivations and why others weren't.

19. **In relation to your responses to question 6 in the provider survey, please explain:**
    - **a.** Why did you agree/disagree with the four statements?
    - **b.** Do you think the position is likely to change in the future?
    - **c.** If prevention is a focus for commissioners, please can you provide any practical examples of this.

20. Why does your answer to question 7 in the provider survey best describe your plans for future prevention activity within your organisation?

Probes:

What is driving/constraining future plans?

Section Three: Implementation and delivery of prevention activity

21. Please tell us more about the factors that have helped and been a constraint/challenge within your organisation in terms of implementing and/or delivering prevention activity.

Probes:

Can you provide specific examples?

Why do you think this has been the case?

Is there anything currently in place, or that could be put in place in the future, to overcome these constraints and/or challenges?

Section Four: Outcomes and impacts

22. Please tell us more about the:

- **a.** Positive outcomes and impacts that you identified in question 9 in the provider survey
- **b.** Negative outcomes and impacts that you identified in question 9 in the provider survey

Probes:

Do you think the outcomes are strongest/weakest for your organisation, your workforce or the people you support?

Are these the outcomes and impacts you would have expected?

Do you think anything could be done to increase the outcomes and impacts of prevention activity?

23. If interviewee has indicated that no monitoring and tracking of the impacts of prevention activity is undertaken, why is this?

Probes:

Are there any barriers and/or constraints in doing so?

Section Five: Future of prevention activity

24. In relation to your responses to question 11 in the provider survey:

- **a.** Why you do agree/disagree with the statements?
- **b.** If strongly agree/agree, how could these outcomes be achieved?
- **c.** If strongly agree/agree, what do you think needs to be put in place before this can happen?
- **d.** If strongly agree/agree, what are the barriers and/or challenges in achieving these statements?

25. Is there anything else about the prevention agenda or activity you would like to add?

Stage Four: Commissioners Online Consultation

Current prevention services to facilitate the role of social care in prevention

1. **a.** Are services actively commissioned under the prevention agenda or does prevention happen as a result of the service provision and/or business as usual?

   b. Are there plans for how this will change in line with the prevention agenda?

2. What type of service provision is currently commissioned specifically under the prevention agenda?

Outcome measures and contract implications

1. Does prevention specifically feature in contractual agreements?
2. Do you commission for specific prevention outcomes?

   If yes, what are these and how are they measured?

Current and future policy direction for social care

1. What is your understanding of the current and future health and social care policy direction for prevention?
2. What are the commissioning implications for prevention policy drivers?

Challenges and/or barriers of commissioning for prevention, including the integration agenda

1. What are the key challenges and/or barriers to effective prevention work in social care?
2. Do you have any suggestions how these can be overcome?

Positives/impact/tensions of local communities and environment on commissioning for prevention

1. What influence does the local community have, either positively or negatively, on commissioning for prevention?
2. What are your current and/or future plans to consider the role of co-production in commissioning and market shaping for prevention?

Appendix B: Cross-tabulation

This Appendix provides results of the cross-tabulation of provider survey responses by residential and non-residential care providers.

Table B.1: Question 1

	% Non-residential providers				% Residential providers			
	Strongly agree/agree	**Neither agree nor disagree**	**Disagree/strongly agree**	**Don't know**	**Strongly agree/agree**	**Neither agree nor disagree**	**Disagree/strongly agree**	**Don't know**
There is a clear policy direction for prevention within the adult social care sector.	56%	9%	25%	9%	58%	6%	30%	5%
I have a good understanding of the prevention agenda.	67%	11%	18%	4%	70%	11%	17%	1%
Social care, by its very nature, is about prevention.	72%	12%	16%	0%	77%	14%	6%	3%

Source: Provider survey (n=302). Percentages may not sum to 100% due to rounding.

Table B.2: Question 2		
	% Non-residential providers	% Residential providers
Monitoring and tracking of physical health concerns	89%	94%
Close working relationships with colleagues in other sectors	92%	88%
Support for staff mental health and wellbeing	95%	84%
Procedures to provide people accessing care and support with advice and guidance to promote healthy lifestyles	89%	86%
Support for the diet, hydration and nutrition of people accessing care and support	79%	87%
Support for the mental health and wellbeing of people accessing care and support	78%	87%
Exercise and movement plans to promote physical health	67%	86%
Proactive procedures to promote self-care and self-management amongst people accessing care and support	81%	79%
Activity focussed on Making Every Contact Count	82%	71%
Support for staff to advise on physical health, diet, nutrition, exercise etc.	71%	64%
Links with social prescribing services	66%	56%
Falls prevention	60%	65%
Source: Provider survey (n=302). Respondents could select multiple answers.		

Table B.3: Question 3		
	% Non-residential providers	**% Residential providers**
Financial benefits for my organisation	8%	11%
Help my organisation to manage the increasingly complex nature of the needs of people supported	82%	74%
It was in line with the culture and vision of my organisation	84%	86%
Reputational benefits for my organisation	73%	72%
To align with the health and social care policy agenda	75%	78%
To improve outcomes for people you support	90%	94%
To meet commissioners' contractual expectations	68%	70%
To meet Care Quality Commission (CQC) expectations/regulation	87%	79%
Source: Provider survey (n=302). Respondents could select multiple answers.		

Table B.4: Question 4								
	% Non-residential providers				% Residential providers			
	Strongly agree/agree	Neither agree nor disagree	Disagree/strongly disagree	Don't know	Strongly agree/agree	Neither agree nor disagree	Disagree/strongly disagree	Don't know
Prevention activity is embedded within the everyday roles of staff within my organisation.	91%	4%	6%	-	91%	7%	2%	-
Prevention currently features within my organisation's policies and strategies.	94%	3%	3%	-	88%	6%	4%	3%
Prevention is a focus for workforce development within my organisation.	90%	6%	4%	1%	84%	12%	4%	-
Prevention is a focus for local commissioners.	68%	7%	17%	7%	71%	11%	4%	13%
Source: Provider survey (n=302). Percentages may not sum to 100% due to rounding.								

Table B.5: Question 5		
	% Non-residential providers	% Residential providers
We plan to introduce new activity (please specify).	36%	39%
We plan to recruit new staff to prevention focussed roles (please specify).	16%	15%
We plan to link in better to other local services (e.g. care navigators, link workers)	36%	31%
We plan to expand the activity we already have in place.	54%	49%
We do not plan to introduce any new activity.	21%	29%
I am not sure what we plan to do next.	18%	11%
Source: Provider survey (n=302). Respondents could select multiple answers.		

Table B.6: Question 6								
	% Non-Residential providers				% Residential providers			
	Helped	Constraint/challenge	Neither helped nor been a constraint/challenge	Don't know	Helped	Constraint/challenge	Neither helped nor been a constraint/challenge	Don't know
Ability to recruit and/or retain staff	23%	48%	25%	4%	23%	16%	58%	2%
Amount of staff time available to deliver prevention activity	24%	42%	27%	7%	30%	30%	36%	3%
Availability and access to local community facilities	46%	25%	25%	4%	52%	13%	33%	1%
Care Quality Commission (CQC) expectations/regulation	48%	12%	35%	5%	43%	11%	43%	2%
Knowledge, attitudes and behaviour of staff	57%	17%	25%	1%	68%	8%	24%	1%
Leadership within my organisation	71%	5%	24%	-	70%	5%	24%	1%
Level of funding	16%	48%	26%	10%	16%	47%	37%	4%
Partnership working with colleagues (e.g. in health, housing, emergency services etc.)	57%	13%	27%	3%	47%	7%	46%	1%

Table B.6: Question 6								
Priorities of local commissioners – e.g. asset-based commissioning	19%	31%	36%	14%	22%	8%	56%	13%
Relationships with the families of people supported	62%	9%	25%	4%	52%	3%	43%	1%
Size of my organisation and/or setting	44%	9%	38%	9%	28%	7%	63%	1%
Support, guidance or training resources (e.g. All our Health e-learning or Population Health Portal e-learning, other resources and guidance)	59%	7%	26%	8%	34%	5%	61%	1%
Use of technology within my organisation	53%	13%	29%	5%	38%	5%	57%	1%
Source: Provider survey (n=302). Percentages may not sum to 100% due to rounding.								

Table B.7: Question 7								
	% Non-residential providers				% Residential providers			
	Positive impact	Negative impact	No impact	Don't know	Positive impact	Negative impact	No impact	Don't know
For your organisation:								
Delivery of my organisation's vision/aims	72%	-	20%	8%	73%	-	22%	5%
Levels of staff recruitment and retention	40%	14%	38%	8%	41%	3%	54%	2%
Profile/awareness/reputation of my organisation	78%	-	16%	5%	61%	1%	27%	10%
For your workforce:								
Employee stress and burnout	41%	7%	41%	10%	31%	5%	53%	11%
Levels of job satisfaction	73%	3%	19%	4%	71%	2%	22%	4%
Staff awareness and knowledge about their own health and wellbeing	73%	3%	19%	5%	71%	2%	22%	3%
Training opportunities	79%	2%	15%	3%	52%	1%	45%	3%
For the people you support:								
Achieving better outcomes for people you support	83%	1%	5%	11%	86%	-	10%	4%
Source: Provider survey (n=302). Percentages may not sum to 100% due to rounding.								

Table B.8: Question 8								
	% Non-residential providers				% Residential providers			
	Strongly agree/agree	Neither agree nor disagree	Disagree/strongly disagree	Don't know	Strongly agree/agree	Neither agree nor disagree	Disagree/strongly disagree	Don't know
There should be a change in commissioning to focus more on prevention activities.	86%	7%	3%	5%	69%	15%	11%	6%
There should be a greater focus on prevention within Care Quality Commission (CQC) inspections.	65%	11%	20%	4%	67%	11%	16%	6%
There needs to be a standardised process of monitoring prevention outcomes across providers in the sector.	83%	10%	5%	3%	85%	8%	4%	3%
More support, guidance and training is needed for social care providers to help them deliver prevention activity.	86%	6%	8%	-	91%	4%	6%	
There needs to be greater integration of health and social care in order to maximise the benefits of prevention activity.	97%	1%	1%	1%	95%	3%	1%	1%
In the future, there are likely to be changes in job roles within the adult social care sector as a result of prevention activity.	40%	13%	11%	33%	43%	9%	10%	44%
In the future, there are likely to be changes in the profile of the adult social care sector workforce as a result of prevention activity.	46%	14%	7%	34%	41%	9%	10%	41%
Source: Provider survey (n=302)								

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