Draft Response dated 28th November 2011

1. **Improving quality and developing the workforce**

The quality of care people receive is a major concern for users, their families and the public more widely.

a. Should there be a standard definition of quality in adult social care as quality can often be interpreted differently? What do we mean by it and how should it be defined? How could we use this definition to drive improvements in quality?

We would not support a standard definition of quality in social care - quality standards should be set with, agreed and monitored by customers as an individual and person centred concept. The CQC essential standards framework already exists and is used to define the essential standards of care that should be provided by social care services, above which a personal definition of quality should be defined through the consistent use of person centred care plans .

b. How could the approach to quality need to change as individuals increasingly fund or take responsibility for commissioning their own care?
How could users themselves play a stronger role in determining the results that they experience and designing quality services that are integrated around their personal preferences?

If customer defined standards are applied then the approach would not need to change but would be consistent with the principles of personalisation. Customers need to be able to rate services and make their choices of which service to use based on their own experience of services feedback from other users. In Rotherham we are developing an emarketplace which will provide customers with this facility . In addition, we have a scheme called Home from Home which provides customer based information about the quality and experience of homes. The Home from Home scheme produces a report based on the contracting process and also personal experience and provides homes with an individual rating, bronze, silver or gold. This information is placed on the council's website to give prospective customers an insight into the quality of the service Having developed this scheme successfully within care homes, we are now extending it to domiciliary care services.

Customers are able to play a stronger role in determining the results that they receive by participating in assessment processes (through the local Self Assessment Questionnaire), ensuring that their needs have

been correctly identified and then working to develop effective and person centred support plans which are outcome focussed.

c. How could we make quality the guiding principle for adult social care? Who is responsible and accountable for driving continuous quality improvement within a more integrated health and care system?

The quality of services is a shared responsibility – commissioners, providers, and other stakeholders such as the CQC have a key role to play in determining and defining quality. Customers should be involved in evaluating quality and providing feedback to services, through customer inspector roles, service user meetings, complaints, quality assurance checklists and questionnaires etc The CQC portal in development currently, will be a useful development so that information on quality can be shared.

d. What is the right balance between a national and local approach to improving quality and developing the workforce? Which areas are best delivered at a national level?
(see below)
e. How could we equip the workforce, volunteers and carers to respond to the challenges of improving quality and responding to growth in demand? How could we develop social care leadership capable of steering and delivering this?
(see below)
f. How could we improve the mechanisms for users, carers and staff to raise concerns about the quality of care? How could we ensure that these concerns are addressed appropriately?
(see below)

(d, e , f) To achieve a workforce with the right skills to provide care and support with compassion and imagination requires **strategy to be developed at a national level** (to give effective leadership of the social care sector and steer the targeting of local resources linked to Government Policy) aligned with a **local workforce plan** (based on InLAWS) that accounts for the local region/area policy and procedures and, in particular, the available local labour market (including paid workforce, communities, friends, family members, volunteers).

Setting standards for the workforce at a national level helps:

- To improve the calibre of those entering the social care workforce and their regulation by having clear national recruitment, induction and training requirements to be met irrespective of geography

- To regulate registration and re-registration of the workforce linked to continuing professional development requirements of professional or regulatory bodies

- To develop qualifications (awards / units) to meet customer needs around Government Policy such as Dementia, Carers, and End of Life.

- To best target research around return on investment/expectations of learning and development linked to social care outcomes

- To consult and engage with a work sector more proficiently and cost-effectively

- With developing national competency (behavioural) frameworks for key areas such as Dementia, Safeguarding, End of Life, etc

- With workforce intelligence collation and analysis to assist benchmarking and strategic planning of funding for workforce development to meet skill shortages such as numbers of social workers or personal assistants

- To develop national toolkits to help employers (local authority, independent sector, service user employers alike) with key workforce tasks such as workforce planning, recruitment, and workforce development plans

- To set national expectations or requirements around the amount of money and time that must be invested in developing the workforce, for example, 3% of salary costs or monies that must be 'ring-fenced' for investment on targeted themes such as dementia.

At a local level, the above may then help with:

- Service commissioning - Shape workforce requirements into tenders/contracts to improve standards for customers

- Workforce development - Prioritise investment locally in learning and development so that the workforce has relevant qualifications and access to training courses

- Recruitment and selection - Provide materials for recruitment campaigns and selection activities

- Retention – Take targeted action to address high staff turnover levels and limit number of vacancies and hard to fill posts

- Resources - Develop new types of worker

- Intelligence - Use workforce data to set wage/salary reward packages and provide a 'level playing field' for tendering

- Performance – Set local indicators to track progress against national priorities and policy.

Equipping the workforce, volunteers and carers could be achieved by the following:

Employability

Set up a national volunteer register / academy.

Make careers in social care attractive to young people or those seeking second careers.

Make preparing to care courses accessible to all people and those on benefits are not penalized or restricted with ability to access.

Rewards

Set minimum wage requirements for those working in social care that is above the national minimum wage.

Skills

Develop mandatory 'M' level qualification and put requirements in place for senior managers to achieve it.

Devise and share case studies of what works in leadership.

Set up a national coaching and mentoring scheme for leaders to support development of both mentee/mentor and coach/coachee.

Set up a national 'job swap' secondment scheme/programme for senior managers between local authorities and independent sector.

Set up national e-learning platform for accredited e-learning modules for personal assistants and carers with access to wider workforce to access free of charge.

Resources

To locally actively engage in community skills development to develop market capacity across neighbourhoods.

2. Increased personalisation and choice

The needs and circumstances of every person receiving care and support are unique to them. Whether a person funds their own care or receives a personal budget we want people to have genuine choice and control over the services they buy and receive.

a. How could we change cultures, attitudes and behaviour among the social care workforce to ensure the benefits of personal budgets, including direct payments, are made available to everyone in receipt of community based social care? Are there particular client groups missing out on opportunities at the moment?

Through taking a proactive and creative approach to personalisation, Rotherham has an excellent track record in delivering choice and control to customers. Over 60% of people have been allocated a personal budget and we have a high level of take up of direct payments, including among those groups , such as people with mental health needs, where the roll out of direct payments has proved challenging elsewhere. We have used inspiring case studies and creative staff development techniques to inform and enthuse the workforce.

Learning Disability services in Rotherham work on the basis of person centred planning for people - we have a full time co-ordinator for this who is/has extended this concept into working with our private/independent providers.

Work has also been done with the VCS and provider market to ensure that transition plans are in place for future under personalisation.

b. What support or information do people need to become informed users and consumers of care, including brokerage services? How could people be helped to choose the service they want, which meets their needs and is safe too? How could better information be made available for people supported by public funds as well as those funding their own care?

Effective information , using a range of channels , which promote the services available, in an integrated way, working with colleagues

from health services and the voluntary sector to ensure that people are effectively sign posted. In Rotherham, we follow people up once they have been signposted to other services, to ensure that the service they received has been effective and has met their needs.

c. How could the principles of greater personalisation be applied to people in residential care? Should this include, as the Law Commission recommends, direct payments being extended to people (supported by the state) living in residential accommodation? What are the opportunities, challenges and risks around this?

Given that there is a choice directive supporting individual's choice of residential care, providing a direct payment would not make a great contribution to the principles of personalisation. Effective person centred care planning, taking and using 'life stories; engaging residents and their families in the running of the home and ensuring that choice and control are embedded in the way that staff are trained, and the service is operated is essential. It is possible that a menu of services could be developed in residential care as opposed to "all or nothing" scenario.

d. How could better progress be made in achieving a truly personalised approach which places outcomes that matter to people, their families and carers at its heart? What are the barriers? Who has responsibility and what needs to change, including on the legislative front?

There is potential for the development of current users as champions or mentors of the approach and as successful case studies. Input from users is key as it highlights issues from their perspective. Provision of independent support and advice may also assist. Sharing of successful service stories, and developing a bank of evidence based practice . **Outcome based assessments and reviews**.

3. Ensuring services are better integrated around people's needs

People's lives rarely fit into neat compartments. Getting the care we need may involve several different services and agencies. We want to discuss how local services can work better together to meet people's needs.

a. What does 'good' look like? Where are there good practice-based examples of integrated services that support and enable better outcomes?

'**Good' should be defined by the customer and be based on meeting needs and outcomes. There are many examples of integrated services that support better outcomes – Intermediate Care in**

Rotherham is a good example of where services are provided in an integrated way to support people's choice and independence.

Rotherham also has a joint health and social care service for people with a learning disability. This means that funding is pooled and staff are both co located but also jointly managed.
This has increased situations where health and social care can genuinely work together in securing the best outcomes for people. It prevents sterile funding discussions as most people who receive a service will be from the joint funding arrangements. We have a 3 year partnership agreement with health to continue these arrangements We have a joint point of access where all contacts into the service can be filtered and directed to the appropriate source - thus avoiding unnecessary passing of people between health and social care professions. There is therefore much joint working between health and social care professions - for example the joint service is also responsible for an integrated response to safeguarding matters - again co working ensures the best possible outcomes for people through a multi- disciplined skilled response.

b. Where should services be better integrated around patients, service users and carers – both within the NHS, and between the NHS and local government services, in particular social care (for example, better management of long term conditions, better care of older people, more effective handover of a person's care from one part of the system to another, etc)?

Integration of services should be a key and basic principle of all service delivery, to ensure quality of service and a more efficient response.

c. How can integrated services achieve better health, better care and better value for money?

Integrated services can reduce bureaucracy, reduce unnecessary processes and time spent on managing systems, and can provide the right care at the right time to the right people. Integration on its own may not achieve this, services should be designed and delivered in line with best practice and best value principles, learning from others and retaining the customer at the centre, using lean principles.

d. What, if any, barriers to integration should be removed, and how can we incentivise better integration of services at all levels?

The new Health and Wellbeing Boards should ensure better integration, information sharing, systems and process integration.

e. Who needs to do what next to enable integration to be progressed in a pragmatic and achievable way?

f. How can innovation in integrated care be identified and nurture

` **We have been working towards closer working relationships across different health and care professionals for years. Different structures within organizations (that are constantly changing), different funding regimes and eligibility criteria all act as barriers to doing this successfully. Teams and funding need to be integrated with a responsibility for all of the local client group, regardless of their support package and their place of care.**

4. Supporting greater prevention and early intervention

Across health, social care and public health, we want to focus on prevention and early intervention to help people maintain their independence and improve their health and well-being.

a. What do good outcomes look like? Where is there practice-based evidence of interventions that support/enable these outcomes?

   Good outcomes are customer defined and will be unique to each individual.

b. How could organisations across the NHS and local government, communities, social enterprises and other providers be encouraged and incentivised to work together and invest in prevention and early intervention including promoting health and wellbeing?

c. How could we change cultures and behaviour so that investment in prevention and early intervention is mainstream practice rather than relying on intervention at the point of crisis? How could we create mechanisms that pay by results/outcomes?

d. How could individuals, families and communities be encouraged to take more responsibility for their health and wellbeing and to take action earlier in their lives to prevent or delay illness and loss of independence? How could we promote better health and wellbeing in society?

e. How could innovation in prevention be encouraged, identified and nurtured?

Supporting People has developed an effective outcomes framework which supports providers to demonstrate how they are achieving outcomes for customers. We need to build on good practice across Local Authorities, many of whom have been working on these approaches already, to develop a common outcomes framework. Providing advice, support and guidance to people who are not yet in the system, well before they enter it for example looking at employment issues, health problems and housing conditions and availability. Innovation in service delivery can be encouraged through focusing on the needs and changing needs of the customer.

It is the opinion of the Authority that early diagnosis is key to achieving positive outcomes within the social care systems.

5. Creating a more diverse and responsive care market

People want choice and control over their care and support, so they can receive the services which best meet their needs. In the future, individuals will increasingly be purchasing their own services. Those funding their own care will continue to seek a range of services.

a. How would you define the social care market? What are the different dimensions we need to consider when assessing the market (eg type of provision, client group, size of provider, market share)?

We would define the market as providing services for:

- **Older people**
- **Adults with learning disabilities**
- **Adults with mental health issues**
- **Adults with physical disabilities and sensory impairment**
- **Supporting People – including vulnerable adults and young people over the age of 15 years**

It would not cover the provision of services to children except where these interface with child to adult transition services.

These markets will encompass:

- **In-house Council provided services**
- **Independent sector services - including the voluntary and community sector and private sector**
- **Self-funded – non-Council funded**

With the wider development of personalisation, in particular Direct Payments, the market will need to respond to individual need, and

the social care market will become those services which people choose to meet their needs.

b. How could we make the market work more effectively including promoting growth, better information for commissioners (local authorities and individuals), improved quality and choice and innovation?

The previously mentioned e-market place initiative will help with this. An effective market relies on:

- Signposting
- Regular contact
- Feedback from customers and families
- A Market Position Statement
- Provider forums
- Good contracting and service agreements
- Bulletins
- Newsletters
- Mandatory training opportunities

c. Does there need to be further oversight of the care market, including measures to address provider failure? If so, what elements should this approach include, and who should do it?

This will vary by Local Authority. Rotherham already has comprehensive arrangements in place for this, via a database and "eyes and ears" initiative. There are also very good links between the Safeguarding and the Commissioning teams.

There is a need to be more robust, however, around identifying defaults, penalties and incentives. This can be managed by the Local Authorities where it is via their own contracting arrangements.

d. Looking to the future, what could be the impacts of wider reforms on the market? What possible effects would the following have on the market: the recommendations of the Dilnot Commission's report, the roll out of personal budgets and direct payments, and the drive to improve quality and the workforce?

There is an issue around Continuing Health Care funding – Health drivers are to release from hospital as soon as possible, and this can result in an increased use of services such as 24 hour care placements. This increases the dependency of customers. CHC funding should follow customers to their homes to allow more

independent living. The Personal Health Budget initiatives are welcomed, and there would be significant benefit to increasing the pace of development in this area. In addition, promoting the benefits of a jointly commissioned approach to placements, and services received by people who are eligible for CHC would increase efficiencies, improve services for customers and promote integration.

Public Health reform may assist in that when the function moves into Local Authorities there may be a more holistic approach in the future. GP commissioning should also present a positive opportunity as they tend to be focused on small communities and neighbourhoods in a similar way to elected members in Local Authorities.

The funding model definitely needs to be sustainable as ever increasing costs may become a driver away from community based care towards residential as this is relatively cheap. If this isn't addressed we could end up with graded social care based on ability to pay and therefore reinforcing social inequalities.

6. The role of the financial services sector in supporting users, carers and their families

The financial services industry believes it can play a more important role to help people plan and prepare for the costs they will face in older age. The choice and range of financial products, such as insurance, to help people pay for care is currently very limited.

a. In the current system, what are the main barriers to the development of financial products that help people to plan for and meet the costs of social care?

- **Complexity of the current charging systems and lack of clarity on who pays what/ how much the Government will contribute and variations on how much you pay based on where you live**
- **Too much risk**
- **Lack of a cap on funding makes the premium too high**
- **Low take up because there is no real incentive for people to purchase insurance products if the state meets the burden of last resort**
- **Low take up due to the lack of awareness of the products available. Most people contribute far more than they will ever receive back. While this is beneficial to the insurance company, it might not be for the client?**

b. To what extent would the reforms recommended by the Commission on

Funding of Care and Support overcome these barriers? What kinds of products could we see under such a system that would be attractive to individuals and the industry?

- **Capping care contributions will provide more stability/ less risk and is likely to result in more varied products being made available**
- **Products which are more affordable will obviously stimulate interest**
- **Equity release schemes, Immediate Needs annuities**
- **Pre funded insurance products**
- **Critical illness products**

c. What else could the Government do to make it easier for people to plan financially for social care costs?

- **Provide more clarity and simplify the funding arrangements**
- **Remove the post code lottery affect by being more prescriptive and allowing less discretion**
- **Ensure that new insurance products are regulated effectively and minimise the 'small print' to give customers more confidence**

d. Would a more consistent system with nationally consistent eligibility criteria, portability of assessments and a more objective assessment process support the development of financial products? If so, how?

- **Yes**
- **By being more prescriptive and giving less discretion**

e. Would the reforms recommended by the Commission on Funding of Care and Support lead to an overall expansion of the financial services market in this area? How would this affect the wider economy?

- **With simplicity, less risk and effective regulation then yes it's likely to have a significant impact.**
- **The resultant reliance on the state will reduce the number of self funders.. Predominantly providers fees for self funders are higher than those funded by the state. This could put providers viability at risk, particularly in some localities.**

f. What wider roles could the financial services industry play? For example, in:

raising awareness of the care and support system?
providing information and advice around social care and financial planning?

encouraging prevention and early intervention?
helping people to purchase care, or purchasing it on their behalf?
helping to increase the liquidity of personal assets?

Providing investment into the care sector

As a Local Authority, we have significant concerns about this approach. It is felt that adult social care should be state funded through a progressive tax system. In particular, the concern about reliance on the financial services sector could create problems of affordability, thus impacting disproportionately on the most vulnerable and deprived.