Appendix 4

Draft Response to “Caring For our Future.”

1. What are the priorities for improved quality and developing the future workforce?

Until the funding issues are resolved and adult social care is put on a firm financial footing with enough money to deliver good quality care, we will be left tinkering round the edges in a market that teeters on the verge of instability. Service users deserve good quality services and the current and the future workforce deserve to be paid a living wage and to have adequate training and career progression routes.

There do need to be clear outcome based quality standards which are evidence based, measurable, meaningful, established nationally and regulated locally. Examples of good outcome based quality indicators which have been co-designed with service users, family, staff and commissioners include the ***Making It Real*** and the ***REACH*** standards. Local inspection would have the added advantage of developing good relationships with local providers, working alongside local commissioners and jointly developing and where necessary enforcing a culture of quality.

The role of CQC has suffered from the movement of social care responsibilities into a shared location with health and from the outside looking in, it appears that the focus has almost entirely shifted from social care to health care, as there has been an increasing recognition of some of the poor performance of hospitals and other health services. Whilst this is to be commended, it should not be at the expense of social care.

The quality national standards should set the framework for expectations of the workforce, and services should demonstrate that performance is monitored against these standards.

We believe that personal assistants need to be regulated and that clear standards should be set which include minimum qualifications. There needs to be considerable attention given to ensure the quality assurance of non-regulated services and the development of clear national approaches with respect to this that are robust enough to weather legal challenge from providers.

Given the experience of the move of CSCI into CQC and the watering down of attention to social care, we do have some concerns about the move of the General Social Care Council into the Health Professions Council and would want some reassurance that social workers will be given the same status as clinicians and therapists and that there will be no watering down of a focus on adult social care.

We already have mechanisms in place for people to raise concerns about the quality of care – however people do need to be able to access support to do this and the role of independent advocacy and Healthwatch will be instrumental in ensuring this. Again this cannot be done

without adequate funding. Consideration should be given to fully funding and enacting the Disabled Persons, Consultation Representation and Services Act.

Safeguarding is an important issue for us and we welcome the harmonisation recommended by the Law Commission and putting the Adult Safeguarding Board on a statutory footing in keeping with the importance of the matter and equalising the status of both adults' and children's safeguarding issues.

2. What are the priorities for promoting increased personalisation and choice?

Personalisation should be applied to all aspects of health and social care including residential care – this needs to include direct payments.

The issues of supporting a social care workforce to be creative, empowering service users and carers to make different choices and developing a flexible market that offers choice, must all be dealt with at the same time – realistically this will be an incremental process and therefore we need to develop a staged approach to supporting the three key groups of stakeholders in this. We know that we need to offer a menu of options from people who just want a safe traditional service, but within those parameters when they become more comfortable or a crisis has passed, can begin to demand flexibility in times and tasks; and people who want fully fledged direct payments and may just need signposting for support with accountancy and information on choices.

Social work training needs to be addressed – if newly qualified social workers are to think outside of services, then placements need to be with brokers, advocates and service users, as well as the more traditional placements.

There is endless evidence and much research that has been carried out into this area. The recent POET evaluation identified many barriers and facilitators for promotion of personal budgets and this gives a good overview of how increased personalisation and choice can be promoted through areas such as:

- Good relationships with between social workers and service users and their families
- Timely decision making
- Knowing the budget up front
- Knowing what you can and can't spend your personal budget on
- Help to plan

3. How can we take advantage of the Health and Social Care modernisation programme to ensure services are better integrated around people's needs.

The biggest barrier to moving forward in developing integrated services is the lack of funding and the cost shunting from health to social care, the lack of trust and positive working relationships between the key agencies. The current policy of funding adult social care

through the PCT has led to the PCT redefining activity in rigidly defined clinical terms and reducing funding in all other areas including prevention. The pace of change within the sector has meant, that in very challenging times, people are striving to develop relationships with colleagues in the health service who are constantly changing in roles and responsibilities. The financial pressure put on health services, and the often short-sighted approach which many PCTs have taken, means that cost savings are usually focused on community services which effectively cost shunt to adult social care budgets. The fact that money is being trickled to Councils through the PCTs means that PCTS have a view that the social care money is not to prevent adult social care further tightening its belt but to prop up services which the PCT no longer wishes to fund.

There are already some good examples of health and social care integration on the ground – locally we have the model of Unique Care which now works with all people aged 18 and above, identifying those at risk of frequent admittance to hospital and through close practice based integrated working supports patients to remain healthy and well at home for longer. This was one of the services from which the local PCT withdrew funding.

There needs to a whole system approach to the provision of care from low level prevention to high end acute and specialist care and a recognition of how we can better work together. This will be a gap in GP knowledge and should form part of the authorisation process.

As the PCT clusters grow larger and transform into commissioning support bodies for local GPs, the conversations will be more difficult and it will only be through a fully functioning Health and Well-Being Board that we will have a chance of developing a properly thought through range of services which meet our local residents' health and social care needs. This will need to be backed by adequate funding, not shared poverty.

4. What are the priorities for supporting greater prevention and early intervention?

Innovation in prevention can best be nutured by working with people who are already in the "system" and those on the cusp to identify what would best support them to remain healthy and active. Services should be commissioned using a clear outcomes framework and not tied to delivering in a set way.

Services such as reablement and telecare have the greatest benefit for health rather than social care, and yet are funded almost exclusively through social care. There is a considerable evidence base which supports this and which has yet to be taken on board by health colleagues who are busy firefighting the cost of acute services.

Local priorities will be determined through the JSNA, and within this, public health will have a key role to play, through identifying the key determinants for local health issues, health inequalities and in providing education, health promotion and supporting local health and social care services to move forward.

5. What are the priorities for creating a more diverse and responsive care market?

The two key priorities for the market are clearly stabilising what is good and replacing what is not so good with more creative, innovative services. There are real challenges to the stability of service provision, both for larger companies as Southern Cross as demonstrated, and smaller companies or voluntary sector organisations who have either lost funding or who cannot manage the risks that a personalised market brings. Funding services so that quality is not compromised is key in this.

Local solutions are best for small companies and voluntary sector organisations – ways of risk sharing and supporting local small organisations to take part in tender processes need to be developed. Where possible, pump priming to market test new initiatives should be offered and it would be worthwhile looking at developing a national market stimulation exercise with pilots in the way that the DH supported the development of personal budgets through IBSEN.

In the main, tender processes and the like would assure local commissioners of the financial viability of most organisations, and locally, we have already developed the skills required to move cohorts of people from one provider to another in a way which provides reassurance and service continuity. However, the larger organisations which dominate the care sector do pose a threat should they become unstable in the way that Southern Cross has done.

6. What role could the financial services market play in supporting users, carers and their families?

The recommendations of the Dilnot Commission provide some interesting challenges for the financial sector, which, it seems, is unlikely to actually rise to this challenge. Expert opinion is that there are still too many unknown variables, even withstanding the known figure of the recommended £35,000, for insurance companies to want to begin to insure this field. It is also highly unlikely that people will pay up to £17,000 up front just in case they need care. This is particularly true of people on low incomes and no or low assets, who are unlikely to benefit at all from the Dilnot proposals as they focus on people with assets.

Given the overall difficulty in predicting who will incur care costs, it is hard to imagine people paying for potential social care needs from depleted incomes, including lower wages, benefits and pensions as opposed to meeting health or house insurance needs.

However, other existing mechanisms could be used to help people plan for the future. Pension funds and retirement planning could all include information on adult social care as part of the process.

People often make decisions about adult social care in crisis and older people are always worried about being able to meet the costs of their care. There should be impartial financial

advice available for people as part of any admission process to residential care and organisations would need to think sensitively about where this best sits. Local authorities may not always be part of this process.

7. Do you have any other comments on social care reform, including the recommendations of the Commission on Funding of Care and Support?

The Commission and the Coalition Government have still failed to address the current gap between the available funding for adult social care and the current need. This requires urgent attention and it is simply not good enough to state that integration between health and social care will solve all funding problems.

The system proposed by the Dilnot Commission is the fairest and most equitable system that has been proposed to date, and on that basis we would support the recommendations being accepted with a £35,000 cap. However, this needs to be fully funded by the Government outwith the existing social care budget.

We have some concerns, that the very poor would still be disadvantaged, that is those who are asset poor and on low incomes, but we do recognise that the Dilnot Commission have attempted to mitigate the impact as much as they could from the perspective of assets. We would recommend that further attention and analysis be given to the housing costs outlined within the Dilnot report as it would leave those on low incomes such as the state pension with very little money to meet personal needs such as clothing and buying gifts for family members.

We support the portability of social care assessments as long as these remain separate from the decision around how this need will be met.

We also recognise that to fully implement the full range of recommendations, including information and advice, assessing and tracking self-funders etc. that there will be considerable call on the Council's resources and this must also be fully funded.