COMMISSIONING IN ADULT SOCIAL CARE

THE LGIU AND MEARS THOUGHT LEADER SERIES – A SUMMARY

LGiU
LOCAL GOVERNMENT INFORMATION UNIT

MEARS

Contents

Background

From May 2013 – February 2014 LGiU worked in partnership with home care provider Mears to deliver a series of roundtables for our Adult Social Care Thought Leader Series. The series followed on from our report published October 2012, "Outcomes Matter: effective commissioning in domiciliary care", and an associated series of regional roundtables.

It was decided that the topic needed exploring in greater depth through a programme of events which would draw together thought leaders in adult social care to focus on different aspects of commissioning. The goals of the network were to share best practice, and discuss how we can achieve tangible change to commissioning in the context of considerable financial pressure.

LGiU and Mears delivered five roundtables, on Market Management, Monitoring and Evaluation, Personalisation and Co-Production, Integration and Workforce Issues.

Roundtables commenced with a short talk from the keynote speaker or speakers, followed by a short presentation from the provider's perspective, delivered by Alan Long, Executive Director of Mears. We then opened the floor to a roundtable discussion chaired by Jonathan Carr-West, Chief Executive of LGiU. Roundtables were attended by around twenty Adult Social Care thought leaders and conducted under Chatham House rules.

This document brings together in one place the notes from the series.

List of Roundtables

Market Management

29th May 2013

Speakers: Professor Keith Moultrie, Director of Public Care at Oxford Brookes University, and Alan Long, Executive Director of Mears Group

Monitoring and Evaluation

10th July 2013

Speakers: Oscar Alexander, Managing Director of Cubicus, and Alan Long, Executive Director of Mears Group

Personalisation and Co-Production

11th September 2013

Speakers: Helen Sanderson, who has led the development of person-centred thinking and planning in the UK over the last fifteen years, and Alan Long, Executive Director of Mears Group

Integration

13th November 2013

Speakers: Duncan Selbie, Chief Executive of Public Health England, Dr Tony Martin, Thanet CCG's Clinical Chair, and Alan Long, Executive Director of Mears Group

Workforce Issues

24th February 2014

Speakers: Lyn Romeo, Chief Social Worker for Adults, Helga Pile, UNISON National Officer for Social Care, and Alan Long, Executive Director of Mears Group

Market Management
29th May 2013

This roundtable asked the question: what role should councils play in market shaping? Speakers included Alan Long, Executive Director of Mears Group, who gave the provider perspective, and Professor Keith Moultrie, Director of Public Care at Oxford Brookes University, who gave an introduction to market management and shaping. Jonathan Carr-West, Chief Executive of LGiU, chaired the event.

The roundtable looked at whether organisations have a vision for the adult social care market in their locality; what market shaping/management means in practice; what levers a local authority has in terms of market shaping; what the adult social care market needs to look like in future to respond to changing demand; what councils will need from providers; what type and quantity of provider organisations will need; and what councils need to do to get there.

Presentations

In his introductory presentation, Alan Long, Executive Director of Mears Group, questioned whether the variety of practice in contract management reflects well thought out localism, or suggests difficulties with sharing best practice. He argued that the adult social care sector needs to improve the evidence base on which commissioning decisions are made, and to bring people together from all different parts of the market outside the context of a tendering process. A philosophy of reablement should run through all work with service users, as commissioning products and not services makes it difficult for them to be seen as part of a more holistic care pathway. Furthermore, health, housing and social care services could be integrated more efficiently. His key points from the provider perspective were as follows:

- The market in social care is very different to other markets for services – it is often fragmented, and people buying these services are often doing so at a time of crisis, with very little information with which to make a choice.

- Mears works with around 90 councils and sees a wide variety of practice in contract management, ranging from framework

contracts with 100s of different providers to contracts with two or three providers. He would question whether the variety of practice reflects a positive picture of well thought out localism, or simply points to the fact that there are difficulties sharing best practice.

- There is still a great deal of discussion about the value of outcome-based commissioning, but councils still invariably commission domiciliary care on the basis of task and time. This militates against better outcomes for individuals as it gives providers an active financial stake in an individual's care need increasing (thus extending the package).

- Councils tend to commission products and not services. Telecare, domiciliary care and reablement are usually commissioned as separate contracts or 'products', rather than a composite set. This makes it difficult for them to be seen as part of a more holistic care pathway for an individual.

- A philosophy of reablement should run through all our work with service users – it should be an ethos rather than a separate service.

- We are too often failing care workers in relation to terms and conditions. The Low Pay Commission has raised serious concerns about wages in the care sector falling below the minimum wage as a result of issues such as the non-payment of travel time. The focus on reducing the hourly rate of care, rather than reducing the overall cost of a contract makes this difficult to manage.

- From a provider perspective, having a market strategy with a clear direction is fundamental for a local authority.

- Health, housing and social care services could be integrated more efficiently. Mears runs services that combine a care contract with a repairs and maintenance contract in social housing for example, allowing carers to identify potential hazards and have them rectified within 24 hours. This does not necessarily need to be part of the same contract with one provider – with better integration and training of staff this could be used in any context.

- As a sector we need to improve the evidence base on which commissioning decisions are made, and to bring people together from all different parts of the market: commissioner, provider and service user, outside the context of a tendering process.

Professor Keith Moultrie, Director of the Institute for Public Care at Oxford Brookes, noted in his introductory presentation that adult social care is a huge market. Councils have increasingly less control, and may find themselves in the role of market facilitator rather than market manager, as they directly commission less and less. The market is very fragmented, with micro providers at one end and enormous multi-national corporations at the other. Local authorities are good at dealing with small providers, but less so with the big ones. In future, councils need to think about how critical planning can be in determining the right mix of care in an area; the use of business development to encourage innovation and support small business ventures; and how to make better use of sheltered housing stock. Local authorities should be capturing and sharing market intelligence, structuring the market and intervening in the market. His presentation set the context with a thorough overview of the current market position in adult social care.

- Adult social care is a gigantic market. £4.5bn was spent on residential care alone last year.

- Over two thirds of people working in adult social care are in the private or voluntary sector.

- There is increasingly less control of social care markets on the part of the council. Self funders and people on personal budgets represent 70 per cent of transactions in adult social care. Local authorities are not the main drivers in this area – the council only purchases 40 per cent of care beds in the South East for example. However, this picture changes regionally and rises to 83 per cent in the North East.

- There is a high level of financial instability. Many frustrated providers are struggling to stay afloat while paying care workers

and delivering quality services.

- The market is very fragmented, with micro providers at one end, to enormous multi-national corporations at the other. There are 12,500 social care providers registered in the UK, 6,800 of which are domiciliary care providers.

- The distribution of care homes also illustrates this changing agenda. In a sample of care homes beginning with the letter B, there were 636 homes, of which 508 were owned by just two groups, Barchester and BUPA. The remaining 128 homes were owned by 17 other companies.

- In his experience, local authorities are good at dealing with small providers, but less so with the big ones. BUPA is a worldwide operation and will have a very different agenda to small, local organisations. Barchester recently spoke about a postcode analysis they had undertaken, comparing themselves to Waitrose, or Majestic Wine.

- We need to have a better understanding of big agendas. The risk profile of companies of this size is very complex, and we cannot understand the dynamics that influence the decision these companies make unless we understand how they operate. On the one hand we need to nurture and support small businesses, but on the other hand, we have to work with large businesses that demand an understanding of a very different set of market issues.

- Small businesses are finding the current financial climate particularly tough, and many will sell out over next few years.

- The Caring for our Future White Paper talked a great deal about provision of information for individuals and a well supported, diverse range of high quality providers. The local authority has responsibility for ensuring a range of services is available and the market position statement must detail how the councils will do this.

- They are currently consulting on further steps to ensure service continuity for people using care and support, should a

provider go out of business.

- In future, councils will need to think about some of the following things:

- How critical planning can be in determining the right mix of care in an area (are we driving demand by building too many care homes for example? Have older people and people with learning disabilities got the facilities they need to remain in the community)

- Use of business development to encourage innovation the care sector and to support small business ventures.

- Better use of sheltered housing stock.

There are three main roles for a local authority in future:

1. Capturing and sharing market intelligence for the benefit of their own organisations and of providers. This positions the authority as a reliable source of information for providers, and supports their role as an honest broker.

2. Structuring the market. This involves ensuring that the local authority is well informed about the market, understands the factors that influence demand and supply and has a clear vision of what good quality care looks like and the outcomes that it will achieve. A commissioner would naturally want to know, for any market, who provides what, where, to whom and at what price.

3. Intervening in the market. Direct intervention may become more limited in future, but could include, for example, stimulating particular parts of the market with financial incentives; offering specialist training; supporting providers with business planning; working with providers and consumers in order to deliver good quality information; creating vehicles for consumer feedback on service provision; or, setting up not for profit ventures.

- It is important to stress the difference between market facilitation and market management. Local authorities may increasingly find themselves in the former role as they directly commission a reducing proportion of the market.

- A market position statement is a very useful tool. The IPC's Developing Care Markets for Quality and Choice (DCMQC) website (http://ipc.brookes.ac.uk/dcmqc.html) includes a range of materials available on this subject. They have recently produced an 'understanding the self funders market' briefing.

Roundtable discussion

The roundtable discussion covered a wide range of themes, which are summarised here.

Market shaping versus market management

Market management

The experience of market shaping/ management differs greatly from council to council. Some local authorities felt that they were still primarily performing the role of 'market manager' rather than 'market facilitator'. One metropolitan borough epresentative noted that due to the level of market failure they have experienced they have had to become a quasi-market regulator like the CQC. There is also pressure from politicians to act as a market manager, rather than a facilitator and take a strong position on issues like low wages for example.

Some councils were taking a more active role still. A county council representative mentioned that they were considering setting up a local authority trading company to respond to the adult social care market. Just to stand still they need to generate income, so are putting themselves in the market.

Market shaping

However, it was also recognised that the direct management role of councils has been diminishing as a result of direct payments and the growth of the self-funder market. Councils still directly commission a significant proportion of the market, and this should not be underestimated. However, this proportion is reducing and councils will have to find ways of influencing the market other than buying directly.

One participant commented that 'market management' can be a misleading term to use to elected members, as it strongly implies that the market can be controlled – increasingly we cannot give those guarantees, so should be careful about the language we use.

Combining roles

A representative of a national charity noted that councils perhaps have two separate roles – one could be termed market management, and relates to services they are buying directly. The other is a broader facilitation role which involves a wider more integrated vision for what local people can access.

Buying services is one lever at a council's disposal, but one of many. Councils can also work with the market to help them understand what people want from services in future, supporting providers to move in the direction of policy change. One participant noted that there is a long-term commercial incentive for businesses as well as a short-term financial one. By providing data and market intelligence you can influence the future direction of a market.

There is a decision to be made as to where a council is interventionist, and where they take a more facilitative role; for example, an interventionist council might decide to refuse planning consent on new care homes. A facilitative approach might look to how greater diversity of provision can be incentivised. These approaches are not mutually exclusive.

The council and self-funders

There was a consensus that the council still has a direct role in supporting those who buy their own care.

It was felt that councils have an important role in shaping the environment in which self-funders bought services, from both a service user and a financial perspective. When self-funders are admitted to residential care too early, they often fall back on council support further down the line. Jonathan Carr-West noted that 25 per cent of self-funders fall back on council funding at the moment. The Care Bill will of course have a major impact on this picture.

Relationship with providers

A participant commented that different providers want to engage in different ways. Some want a high level of 'hand holding' from the council, while others feel they should be able to lead, as they know their customers.

One county council representative noted that they struggled to work with the big players, who showed no interest in engaging with the council. Mears commented that they were consistently frustrated by the lack of engagement from local authorities – in many ways this is more of a challenge then winning contracts. They desperately want to engage, and often find this difficult.

In the past councils have tended to meet with providers when there were concerns about quality, rather than engaging them in a wider discussion about the future of the service. We need to have new and more proactive conversations.

A micro-provider representative noted that they would like to see councils commissioning for diversity, both in terms of providers, and in terms of services. Shared Lives has published a guide to commissioning for diversity they would like commissioners to consider. From their perspective, clarity of intent is the most important thing to see from a local authority.

Regional vs. local commissioning

A representative from a metropolitan borough suggested that to partially redress the imbalance of relatively small authorities dealing with international corporations, there could be more cooperative commissioning at a regional level.

It was noted that the West London Alliance is aggregating all their market position statements.

There was a discussion about the shape and form of potential regional working. It was felt that there would be an appetite for more commissioning on this basis, and that the current model of nine regions would be likely to be used from a geographical

perspective. However, it was also noted that this might not be coterminous with other regional structures such as Local Enterprise Partnerships (LEPs). Some in the group felt that regional commissioning could undermine the local flavour of an adult social care market and take commissioners further away from service users.

Consistent commissioning across the public sector

Social care and health

Because of increasing pressure on budgets we have to do things radically differently. We can't continue to commission inconsistently – one participant commented for example, that we use a high proportion of our budgets to purchase residential care, but have little control over people entering care – we need to manage clinician behaviour among other things. We are commissioning the placements, but clinicians are driving demand.

Whole system and whole council approaches are needed to keep people living independently for longer. One London Borough representative commented that for adults with physical and learning disabilities it is 50 per cent cheaper to keep people living at home rather than in residential care, and it results in better outcomes.

Two tier areas

One county council representative noted that they had 15 districts to work with on housing, so getting the messaging right was crucial. Another remarked that when you brought other partners such as CCGs and the voluntary sector into the equation the picture was even more complex. Community Budgets will play an important role here.

Economic development teams

There was a discussion about the role of economic development teams in a local authority. These teams often play an important role in regeneration, but are seldom part of a wider discussion about market management and commissioning, particularly in a social care context. It was felt that the skills in these teams (developing relationships with private businesses to support them, influencing their behaviour without direct levers and

generating consensus about the future of a locality) could play an important role in adult social care. The work of economic development teams in Nottingham, to make Rolls Royce and Boots a part of the future of the city was cited as an example.

Housing and social care

It was agreed that housing is an often-neglected part of the social care picture and should be included in the integration agenda. If we want people to remain at home for longer then the quality of housing and the support available within it is a crucial part of the discussion. Shared Lives, a model in which individuals in need of support are matched with host families, is one example of care which allows people to remain out of residential care and to have a fulfilling life in the community.

Working more effectively with planning teams was seen as a key area for action, in terms of supporting future proofing and ensuring the right mix of housing is available in a locality, specifically in relation to a shift from residential care homes to other forms of support such as Extra Care.

Outcome-based commissioning

Wiltshire County Council has introduced a commissioning model that pays providers on the basis of the outcomes they achieve for individuals, rather than the time they spend with them.

One participant noted that because so much of the market is outside local authority control it is difficult to achieve outcome-based commissioning – it can be introduced in local authority contracted services, but those engaging primarily with self funders have no incentive to use it. Another responded that we are already in this market through the assessment – the assessment is key in providing quality advice and information and gives the council enormous power in shaping people's choices.

Alan Long noted that in the contract they have for repairs and maintenance there has been a long-term shift away from task time towards more of an outcomes focus. Where previously they were judged against the cost of an individual repair, they are

now asked to work to reduce the cost of the service as a whole over time, while maintaining customer satisfaction levels. All their targets for a contract have incentives built in about tenant-based outcomes. If it can be accomplished in one service area it can be accomplished in another.

A representative of a London Borough commented that it is interesting that there are so many different interpretations of commissioning. In his council they are encouraging people to take personal budgets and the in-house support planner leads on shaping their care plan. The commissioner then has an important role in making sure the support planners understand all the options available to individuals. This contrasts with Wiltshire, where the provider has a more active role in designing the care plan.

Service user expectations

It was commented that a significant element of market shaping relates to the expectations of service users. As the number of self-funders and those on direct payments increase, and people are increasingly becoming commissioners of their own care, how do we manage their expectations, and those of their family and carers? The assessment was seen as a central part of this process, as was the provision of good quality information.

Wiltshire's Help to Live at Home scheme provides the first package of care universally, allowing them to shape the expectations of service users in relation to what care looks like. This helps to avoid the unnecessary creation of dependency on the system.

One county council participant reflected that we need to move towards a more service user-led model in which the capacity and resources of individuals are understood as well as their 'care need'. Rather than simply assessing need we should ask 'what can you do for yourself?'

Professor Moultrie talked about an impressive example of practice in Scotland, where a community development project aimed at encouraging resilience in older people is drawing on the capacity of 65 to 75 year olds to support those aged 75 and

over. Our assumptions about old age need to shift to understand the assets in communities as well as service need.

Eligibility

Professor Moultrie drew attention to the example of the Welsh Government, which has explicitly decided to let go of the Resource Allocation System (RAS), leaving it to individual authorities to make these decisions. They are gambling on the assumption that councils will use the freedom to absorb demand through wellbeing services. There has been no assessment yet of how this has affected eligibility levels.

One participant commented that the debate around 'critical' and 'substantial' can be misleading in that it's often implied that raising the criteria means there are no preventative services. It should be remembered that reablement is pre-FACS.

Conclusion

The roundtable illustrated that the experience of market shaping/ management, and the relationship between councils and providers, differs greatly from council to council - although there was a consensus in some areas:

The need to support self-funders: there was broad agreement that the council has a key role to play with this group, particularly as they become a larger part of the market. This can involve the provision of better information and support, and the shaping of the environment in which self-funders buy services. Increasingly councils will be unable to directly manage all aspects of the market and will have to use influence and facilitation to ensure service users are empowered to get what they want from care.

New relationships between councils and providers: there was broad agreement that in the past, councils have tended to approach providers reactively in response to concerns about quality. A clear desire to have more productive conversations emerged on both the provider and commissioner sides, as part of the wider development of services in this area. Clarity on the part of the

commissioner about the outcomes they are seeking to achieve was seen as crucial by providers.

Regional versus local market shaping: there was the suggestion that more cooperative commissioning could benefit councils at a regional level, particularly when dealing with large residential care providers. However, others had concerns about this approach and felt it could undermine the local flavour of an adult social care market. There was clearly a need to differentiate commissioning models, and find a balance between the efficiencies of large scale commissioning and the responsiveness of a more local approach.

Consistent commissioning: market shaping is made particularly complex in social care by the number of key players, both in terms of local authority departments and other partners in the private, public and voluntary sector.

The picture is even more complex in two tier areas. There was agreement that we need to work better to draw on the resources we already have (such as economic development teams) and to avoid working against one another (as is the case when health and social care provision is misaligned). Health and Wellbeing Boards are beginning to address the latter point, but it is important that housing does not get left out of the equation. In future we need to care for more people in their own homes, so the quality of that housing is a crucial piece of the jigsaw.

Service user expectations: there was agreement that since people are increasingly becoming commissioners of their own care, the sector needs to think about how to manage expectations. The assessment, and the provision of good quality information, was seen as a central part of this process. We need to understand the capacity and resources of individuals themselves, as well as their 'care need'.

Further reading

A number of publications were referenced in the roundtable. Please follow the links for more information.
A range of briefings and other materials on this subject are available online from the Institute of Public Care (IPC) at Oxford Brookes University: http://ipc.brookes.ac.uk/publications/index.php. Commissioning for Provider Diversity, Shared Lives Plus: http://sharedlivesplus.invisionzone.com/index.php?/files/file/184-commissioning-for-provider-diversity/ Independent Ageing: council support for care self funders: http://www.lgiu.org.uk/independent-ageing-council-support-for-care-self-funders/, LGiU Care Now and for the Future: an enquiry into adult social care, LGiU: http://www.lgiu.org.uk/care-now-and-for-the-future-an-inquiry-into-adult-social-care/

Monitoring and Evaluation
10th July 2013

This roundtable asked the question: How do we move away from a currency of time and task towards one based around outcomes? Speakers included Alan Long, Executive Director of Mears Group, who gave the provider perspective, and Oscar Alexander, Managing Director of Cubicus, who gave an introduction to Wiltshire Council's 'Help to Live at Home' scheme. Jonathan Carr-West, Chief Executive of LGiU, chaired the event, which was attended by 11 representatives of adult social care.

The roundtable looked at how outcome-focused local authority work in this area is, whether attendees currently monitor providers on the basis of outcomes, and whether they pay them on this basis, how we move away from a currency of time and task towards one based around outcomes, what techniques or models we can use to reevaluate our monitoring and evaluation in this area, how we can work with providers to help them work in more outcome-focused ways, and what we can do now to share best practice and move this agenda forwards.

Presentations

In his introductory presentation, Alan Long, Executive Director of Mears Group, explained the outcomes Mears is looking at in three distinct areas: outcomes around individuals, outcomes around workforce and outcomes around community.He explained that, in the experience of Mears being commissioned, there is a wide range of practice. Some councils want to move all service users onto Self Direct Support /Direct Payments and devolve responsibility for outcomes to the individual, so that the outcomes then depend on the choices that individual makes.

Others go down a more active market management approach, taking measures that balance the need for a sustainable market with the need for individual choice around services offered. Inevitably, the two approaches can bring some tension between fiscal control and customer choice.He explained that information and evidence is crucial, to develop a good outcomes based approach. Data on where expenditure happens in the system, across health and social interventions, around an

individual, can obviously track the impact of various interventions. There is significant variation across the UK, in terms of the availability of this data.Alan went on to explain that there are two types of outcome measure you can pay a provider against: individual outcomes (the Wiltshire Council route) or broader community or service level outcomes. For example, if 10 per cent of domiciliary care users currently go into residential care in any year, it's the provider's job to reduce that. Both can work and have the potential to reduce long-term cost in the system.

Oscar Alexander, Managing Director of Cubicus, advised Wiltshire Council on how to implement their new IT systems for monitoring and evaluating outcomes. He also advised on the wider set up of the programme.

Oscar explained that the scheme was set up on an individual outcome basis, and that challenge with monitoring at a community level is getting the sample big enough to make the data legitimate.

The system used by Wiltshire Council works in the following way:

Wiltshire Council Adult Social Care (ASC) staff carry out the initial assessment to establish eligibility and outcomes, which are decided on by the individual service user. No detail about the care plan is decided at this stage.

Each individual outcome has a category, for example, 'I can access banking facilities'. Outcomes should be measurable – so the individual is able to access their own bank account to withdraw money when they need. Wiltshire Council ASC says they want it achieved in x number of weeks. Outcomes can be improvement or maintenance outcomes.

The provider is then responsible for designing a care plan to meet the outcomes. It has been challenging to change over to this sort of model, as social workers are used to saying they need a visit in the morning and the evening for example, but these decisions must be passed over to the provider. The plan describes the time, cost and details of activity. It has to be time limited and has to

be reviewed on time. Wiltshire Council ASC can then agree the support plan or ask for amendments. Initially plans bounced back frequently between the commissioner and provider, but the process is now more collaborative.

The provider receives automatic payments every four weeks through the process. There is no invoicing, but their 'Care First' system makes this work. At the end of the support plan, if not all outcomes have been achieved and this is the fault of the provider, penalties of up to 80 per cent can be applied.

If circumstances change in the plan, the provider raises it and an exception is reported. If there is a minor tweak, the provider is responsible. It is in the provider's interest to raise an exception early. The longer you leave a plan that is not working, the greater the penalty.

Providers are responsible for the delivery of the plan, which can include payable outcomes and non-payable outcomes. Non-payable outcomes are those the provider cannot be held responsible for, i.e. that cannot easily be attributed to their work. Payable outcomes must be 'observable', and 'attributable' to the provider's actions.

Improvement outcomes and maintenance outcomes can be in any plan. It is perhaps more likely that improvement outcomes will be in the first plan, but they can be used anywhere, allowing reablement to be a core principle of home care.

There is a core principle of transparency in the relationship with providers. There is a shared case management system on an IT system that everyone can see.

There are five dashboards as part of the monitoring system: department level dashboard, provider dashboard, team level dashboard, individual worker dashboard and individual case dashboard. They provide comprehensive information to commissioners and providers so commissioners can ask the right questions and providers can see how well they are doing.

Wiltshire Council does not use the term reablement, but all service users go through

an 'initial support period'. After that package, individuals are offered another costed care plan from the council provider, but they have the option of taking a direct payment at the same value. Initially, people already in the system who had established care workers were given the option of a direct payment so they could stay with their current provider.

Wiltshire Council has a strong private care market and offering the direct payment option provides competition for ongoing support. They do not see putting people onto direct payments as a motivation in and of itself. Their drivers were around building a sustainable workforce who could be on permanent contracts and have the investment in skills that they need.

They now have four council providers, each with a geographical area for which they hold responsibility, at least for the initial support package.

Roundtable Discussion

Following the presentations, a roundtable discussion took place focusing on outcome-based commissioning in a domiciliary care setting. Debate around Wiltshire Council's 'Help to Live at Home' scheme dominated the conversation. Some of the questions and responses about this model of provision are summarised below.

How does 'Help to Live at Home' fit in with the direct payment agenda?

Oscar noted that Wiltshire Council conducted a big consultation with older people in the area before committing to the 'Help to Live at Home' scheme. It showed that they valued the outcomes they wanted to achieve (with a particular focus on remaining independent). While they valued their individual carer workers, they were more interested in having choice in the type of service they received, rather than the choice of a large number of providers. Oscar commented that Wiltshire Council has responded to their own service users and local situation, rather than national drivers towards direct payments.

What has this meant the cost of domiciliary care?

There have been initial multi million pound savings from removing the inefficiencies in the system. The intention is also that over time the principle of promoting independence will avoid unnecessary dependency occurring. Placing responsibility for care plan design with the provider has freed up council time to focus on assessment, evaluation and monitoring.

Where is the user voice?

The council still assesses eligibility and employs a user focused outcome based assessment with the service user. This is a series of straightforward questions about what they want their lives to look like, allowing them to identify the outcomes they want to achieve. The provider then works with the service user to identify how best to achieve them. They set up the support plan together and it has to be agreed by provider, service user and council. The assessment at the end is undertaken by the council, but is a three-way discussion between user, provider and council. The service user responds to whether their outcomes have been achieved.

How does the council know how much time is spent with a service user?

Wiltshire Council does not monitor the number of hours spent with an individual - they record the total cost of the package. When the initial care plan is drawn up, the provider identifies how many hours of engagement it will require and costs this up, but there is no monitoring of the hours by the council - only the outcomes and whether they have been achieved. The provider is paid the same amount irrespective of how much time they spend. This incentivises the provider to do things more efficiently - but if the service user is dissatisfied at the end, the provider can be penalised.

Could the council end up paying twice if the provider takes them to grant funded services, such as day centres?

The provider is required to cost everything in the support plan. The council would not expect to pay for things that they'd already paid for (such as a grant funded service), but can suggest it should be included as part of the package.

Trusting the provider to develop the plan frees up officer time to focus more on evaluation and assessment.

It was noted that the domiciliary care provider may not provide everything directly. They may link with other services and voluntary sector organisations, and sub contract arrangements if appropriate. For example, facilitating a meal in a community club could be part of the support plan.

Is there a feedback loop from providers to inform councils of a gap in provision, for example, for a day care centre in a particular geographical area?

There are resource specialists who look at the plans overall, but there is no formal feedback mechanism. Conversations with providers are continual, so it might come up in a support planning process. In theory it could cost more to achieve an outcome in one geographical area than another. A more formal process around this might be developed as the scheme beds in. The voluntary sector themselves may provide a feedback loop if they start to receive increased demand for services.

Is it a more risky model for the provider?

Help to Live at Home uses an agreed rate for a standard and specialist hour of care. Plans are costed using these measures, but the number of hours spent with a user are not monitored. Only the outcomes and service user feedback is monitored. Users see the support plan and the outcomes they have agreed.

Alan Long noted that current task and time system is much more risky for providers and is driving down standards. With Wiltshire's Help to Live at Home scheme, the prize is not in reducing the hourly rate, but in reducing total service costs in a long-term, sustainable way that benefits the service user.

Is this model relevant for a service user who has a good relationship with their care worker, and is therefore less interested in outcomes?

Oscar responded that if the outcome doesn't matter to the individual then we have chosen the wrong outcome. He acknowledged that this programme reframes the way an individual looks at care. The intention is that they will see it as

enabling - an intervention to achieve certain goals, rather than an ongoing condition of life, inevitably resulting in dependency. It was noted that dependency may be necessary in many instances, but it is how that dependency is managed, and how unnecessary dependency is not created. For example, a service user might accept that they can no longer dress themselves, but this might be the support they need to allow them to get out of the house and to their job.

Social isolation can be one of the outcomes the plan looks at, so getting people more active in the community might be part of the support plan. Care workers must be more sophisticated to facilitate this, which is why investment in these staff is so important. This is hard to achieve on a traditional framework contract. The challenge is to stop social workers from support planning and to get providers to do more of it.

There was a discussion about expectations and culture. Families may have a different view as to what the service user needs than the service user themselves. And service user's expectations can also be shaped by the care they receive.

If the service user still receives the same activity through their support plan, what is different from their perspective?

Oscar emphasised that the difference is about the relationship between the provider and the customer, and how the activity is planned. The activity could be very different, and there is more evaluation. There is a longer-term culture shift towards supporting independence.

There was a conversation about what outcome-based commissioning actually means. Oscar noted that one common misunderstanding is that an outcome based system does not include activity. There is always activity, but an outcome based system doesn't just focus on the activity as an end in itself. A time-task based plan could in theory look the same as an out-come-focused one, but the difference is it incentivises providers to 1) look at the most efficient and effective way of delivering what the individual needs - which may draw in third sector providers or other services for example, 2) not to create

dependency and 3) to invest in their staff who will need support and training to respond to outcomes. At the moment, providers are incentivised to increase the length of care plans as they are paid for the time they spend with an individual.

One attendee noted that we need to communicate with people better to achieve this culture change – service users, families, providers and care workers.

Are there any other models for outcome-based commissioning?

There was a discussion about community level outcomes, as opposed to individual outcomes. Oscar notes that social impact bonds use a similar model. The problem for local authorities in this system is 1) it's difficult to get the sample size large enough to make the confidence intervals viable and 2) the council is still responsible for assessing each individual case, so can't completely outsource their responsibilities.

The 'max' project

At the end of the discussion, Juliette Malley, Research Fellow at LSE talked about the 'max' project they are delivering, The aim of this project is to find ways to maximise the value of the Adult Social Care Survey (ASCS) and Personal Social Services Survey of Adult Carers' Experiences (PSS SACE) for local authorities. For more information about this project please follow this link.

Next steps

The roundtable illustrated one of the approaches to outcome based commissioning open to councils in the form of Wiltshire Council's 'Help to Live at Home' scheme.

For further information on Wiltshire Council's 'Help to Live at Home' scheme, please contact Oscar Alexander at oscar.alexander@cubicus.co.uk.

You might also be interested to read last year's report from the LGiU, "Outcomes Matter: effective commissioning in domiciliary care" http://www.lgiu.org.uk/outcomes-matter-effective-commissioning-in-domiciliary-care


MEARS

Personalisation and Co-Production
11th September 2013

This roundtable explored the issues surrounding how we deliver personalised care for older people. Speakers included Alan Long, Executive Director of Mears Group, who gave the provider perspective, and Helen Sanderson of Helen Sanderson Associates, who has led the development of person-centred thinking and planning in the UK over the last fifteen years, and gave a presentation on how you put the person at the heart of service delivery. Jonathan Carr-West, Chief Executive of LGiU, chaired the event.

Attendees at the roundtable discussed a number of questions surrounding person-centred care:

- What do we mean when we talk about personalisation in the context of adult social care? What do we mean by 'choice'?
- How personalised is your work in adult social care? Do you make use of person-centred planning?
- How successful is it in your experience? What are the barriers?
- What role do providers play in this agenda?
- Are service users involved in shaping service delivery at a strategic level within your organisation? Do you have any examples of good practice?
- What are the next steps on this journey? What does success look like and what do we need to do as commissioners to get there?

Presentations

In his introductory presentation, Alan Long, Executive Director of Mears Group, explained that Mears have a broad experience of delivering personalised services. As a provider Mears sees many different home care tender documents. Personalisation is nearly always a requirement but when we come to deliver services there are often different understandings of what the concept means in practice. This is one of the reasons that Mears is keen to explore how local authorities interpret and define the concept. He explained that his

understanding is that personalisation is about choice, control and how to put customers at the heart of the organisation – but the issue is in delivery.

He referred to Mears' experience in housing services. Housing landlords have struggled with the concept and while they often don't call it personalisation, they have been trying to do it for many years. Questions were raised such as whether tenants should do their own repairs, whether they should have a choice over what kitchen they get, and the level of consultation, which was appropriate, i.e. at the community or the individual level.

Alan explained that landlords and councils have responded positively to co-production; getting tenants at the heart of decision-making, for example, collective, board decisions on investment. In addition, the consultation process improved because of the Decent Homes programme. Mears have tried to develop this further by creating the Change Club, which is a group of tenants involved nationally who audit and advise Mears in terms of policies and procedures, and with information on issues that might affect the times Mears get in contact with tenants, such as religious preferences and the school run.

Alan said that landlords need to balance the wishes of the individual with the broader community. For example, Mears could let tenants chose the kitchen they get, but this can give rise to issues around maintaining 500 kitchens fitted out in different ways. Landlords will need to balance those longer-term sustainability issues with choice. This has to be an on-going discussion between landlords and tenants.

The biggest challenge to providers is changing the culture of the domiciliary workforce. The workforce needs to react and respond to the user, rather than having a routine.

Alan concluded that if you're starting to think about outcomes, you're starting to think about personalisation.

In her presentation Helen Sanderson of Helen Sanderson Associates, who has led the development of person-centred thinking and planning in the UK over the

last fifteen years, gave a presentation on how you put the person at the heart of service delivery.

Helen explained that there are several practical ways to deliver choice and control:

- One-page profiles of users and staff
- Communication charts and decision-making profiles
- The doughnut
- Person-centred reviews
- Matching support
- Learning logs

One-page profiles of users and staff:
Helen introduced the case study of Hilda who is in residential care at a home called Bruce Lodge. Hilda's one-page profile is a summary of what is important to her from her perspective, and what good support looks like. This is the foundation of personalised services. Helen spent an hour and a half with Hilda, talking to her and creating her profile through having a conversation. Some of the key questions that should be asked are: what is a good day for you? And what is a bad idea for you?

Helen also introduced the case study of Winifred, who is in her eighties, has dementia, and doesn't speak very much. Helen spoke to Winifred's daughters and asked what a good day looks like for her. Helen discovered that when she was younger Winifred was very house-proud and liked to clean, so they arranged for her to be able to spend some of her time cleaning. Beryl, her care worker, found a way to enable Winifred to clean, tidy and fold. This made a huge impact on Winifred's life and happiness.

The one-page profile is incredibly important in encouraging a culture change. For people to be able to direct their own support, staff need to focus on listening.

Helen went on to explain that the next big question is focusing on the staff who provide that support for users. As far as providers can they should match the personalities and shared common interests of staff with service users. Therefore each staff member also has a one-page profile, so providers learn what is important to staff and how to support them. Teamwork is improved and the manager knows how to

support their staff better. Helen explained that having a person-centred approach to staff is vital in achieving person-centred care.

Communications chart and the decision-making profiles: Care workers need to have a good knowledge of users to make sure their care is person-centred. For example, if Winifred is hanging up handkerchiefs it's because she thinks it's Christmas. Staff should not tell her to put them away, but instead ask her what festival it is, and about Christmases in the past. Providers need to tell staff what service users' communications mean.

The doughnut: Helen explained that one of the key areas of stress for carer workers is not knowing what is expected of them. One of the tools useful for this is creating a "doughnut" of what the core responsibilities for staff are, the space where they can create, and the space where they can experiment. For example, with Winifred, staff are instructed that they can experiment with new ways of finding things for her to fold, but they are not allowed to change her routine in the morning, as that's a core duty.

Person-centred review: After 6 months, implementing a person-centred review keeps your person-centred information updated. This can be taken through the review to work out how teams are working in a totality. "Person centred change" aggregates the information from the reviews to work out what is working and not working. This avoids the pitfalls of questionnaires and feedback forms, which need to be filled out by proxy by people who sometimes have an agenda. This can mean that staff or family, rather than the users, are filling out the questionnaires, so providers do not get an accurate picture of what the user is thinking.

Matching support: Fundamentally, providers need to work out what matters to people, and how to provide this, and they need staff on board. The most dangerous situation is where staff are supporting service users they don't like.

Learning logs: These are structured ways of learning about the individual, and what works and doesn't work for them. It stops the one-page profiles being filed away in a desk.

Progress for Providers is a self-assessment for managers, which you can download or fill out online at http://progressfor-providers.org/. You can also email Helen to ask for a copy at Helen@helensandersonassociates.co.uk

Discussion

Managing service user expectations

Alan explained that providers try to match service users with care workers as far as possible but in practice this is a challenge to deliver when there are limits on the number of care workers available, as a result of the way the services are commissioned.

Helen commented that providers need to match service users and care workersas far as possible. This doesn't mean having a "bank" of care workers on hand, but doing as much as is possible to match. It was commented that person-centred care is here to stay, and if service users don't like the care they're being provided with, they will go to a different provider.

Another attendee agreed that choice does not always produce the best outcomes. For example, some service users have refused care from people of certain backgrounds. But the majority should not be ruled by the risk that this might happen.

One attendee commented that local politicians need to understand they will have cases like this as a rarity at their surgeries. They often tend to be risk averse but they need to take political leadership on this issue.

An attendee noted that often providers are the scapegoat, although they try to respect service users' wishes. It was noted that the closure of centres for disabled and older people is often very unpopular locally, but these moves have been made to support the personalisation agenda and there are valid reasons for doing it, and Councillors need to communicate that.

Informed decision-making

Alan commented that choice without advice is just chance, so there needs to be systems in place to help people make the right choices for them. For example, people should be informed about what telecare is and what adaptations they can get.

Culture change

Another officer noted that the necessary culture change, on the ground, is very slow, and when trying to change a system and link all the different silos, there's a sense of trying to keep things running along on a day to day basis, whilst also trying to change things. They noted that there is now a recognition that a culture change is necessary. Providers need to change the perception of people who have been told they have to have one sort of care.

It was commented that councils and providers need to encourage a more motivated workforce. At the moment there is 30% turnover of the workforce because they are so poorly paid. Staff need to be recognised, respected and better paid.

In addition, councils are increasingly reliant on informal support from friends and family, which cuts to council budgets have encouraged.

Improving commissioning and monitoring of outcomes

Another officer commented that they're trying get all the people involved around the table and change how they commission. For example, time-banking is of interest to councils, but staff need to know what it means in order to build it into their plans. Councils' monitoring and providers' reviews need improvement, so that the same reviews with the same outcomes are not repeated.

Local government autonomy

An attendee commented that the Department of Health doesn't seem to understand local authorities and they have different route maps in different parts of the country. They argued that the government needs to give local authorities greater freedom, and instead deal with the issues of funding and regulation.

Strong political leadership

Another attendee pointed to elected members because strong political leadership allows people to go into the right direction.

Areas of consensus

There was a consensus that providers need to work out how to balance the element of choice, so that the personalisation agenda

can align with a council's strategy and providers are able to deliver person-centred care practically.

Attendees also agreed that a culture change on the ground is necessary to see person-centred care delivered, and encouraging a more motivated workforce is part of achieving that.

It was noted that councils and providers need clarity of purpose and to understand what success looks like.

It was also commented that we're seeing more united purpose. Commissioners and providers used to blame one another, and that is the case less and less.

Next steps

It was suggested that everyone at the roundtable could identify cases of best practise and share them.

Suggested reading:
Mark Upton has kindly sent us this link to the provisional results of ADASS's survey into personalisation.
http://www.adass.org.uk/index.php?option=com_content&view=article&id=931&Itemid=489

Integration
13th November 2013

This roundtable explored the issues surrounding how we achieve integration in social care, health and housing. Speakers included Alan Long, Executive Director of Mears Group, who gave the provider perspective, Duncan Selbie, Chief Executive of Public Health England and Dr Tony Martin, Clinical Chair of Thanet CCG. Jonathan Carr-West, Chief Executive of LGiU, chaired the event.

Attendees at the roundtable discussed a number of questions surrounding integration:

- What should the integration of social care, health and housing look like from a local authority perspective? What does it look like in your locality?
- How do we foster a culture free of institutional and departmental 'silos'? What are the barriers?
- How do we ensure budgets are aligned across departments and organisations to achieve better results for service users? Can a person-centred approach deliver more integrated provision?
- Can shared commissioning deliver integration?
- What are the next steps on this journey? What does success look like and what do we need to do as commissioners to get there?

Presentations

In his introductory presentation Alan Long, Executive Director of Mears Group, explained that, as a result of the range of services the company provides, Mears are as close as possible to being a service provider delivering on the integration agenda. He said that the biggest barrier to achieving integration is that the strong support for integration in councils' strategic papers is not carried over into the commissioning process.

The more integration is unpicked into a whole range of individually commissioned services, the harder it is to deliver integration. He gave Torbay as an example of local authorities and CCGs working together. He explained that such a model encourages providers to support the local

authority and the CCG, to work together and respond as a consortia.

In his presentation Duncan Selbie, Chief Executive of Public Health England, explained that discussions about health and social care end up being far too narrow. Hospitals regard community based services as adjuncts to discharge. The discussion tends not to be around health, but around hospitals, and to conflate health with the NHS. He said that good health is not just the absence of illness; it's a lot more. This is a key reason for poor performance on health.

He argued that there are five risks that take life early. These are: tobacco, hypertension, conditions associated with eating too much, conditions associated with not exercising enough, and conditions associated with drinking too much.

He argued that the sector is not acting on the causes of misery. Hospital clinicians are concerned with long-term conditions, but the people experiencing ill-health are concerned with misery and depression. He asked: what do we mean when we talk about health? Fifty per cent of health is down to individual behaviours. For example, one in five people smoke. Thirty per cent of health is down to an individual's environment. The elderly are more interested in companionship than the presence or absence of disease. Only the remaining twenty per cent of health is down to health care.

Duncan argued that it is the responsibility of the 152 upper tier authorities to improve health, not to provide a public health service. The public's health will be improved by the factors that make the biggest difference, i.e. individual behaviours and individuals' environments, which local authorities are well placed to help with.

He noted that the performance of the UK on length of life and life without misery, compared to other nations which spend a similar amount, is very poor. The UK has stood still over twenty years in misery terms. This means that people are living longer, but in misery.

Duncan outlined three truths:

1. There is no more money, and the sector cannot spend its way out of problems

2. There is no grand strategy for the sector, and changes need to be driven from within rather than handed down

3. The sector is spending money on hospitals, which is not the best response

Duncan ended his presentation by saying that he is looking to the leadership of CCGs to take the sector forward on integration.

Dr Tony Martin, Clinical Chair of Thanet CCG, argued that GPs and doctors have fostered the myth they have answer to health questions but, as Duncan Selbie explained earlier, fifty per cent of our health is down to individual behaviours. However, patients aren't interested in this message.

Dr Tony explained that the culture of organisations is one of the most important factors in delivering integration. The important question to ask is: what are the metrics we're looking to get delivered and why? What do we want to get out of integration? What would we want for our families?

He felt that, as a result of a surplus of funding over the last ten years, spend has been without thought, and there has been a lack of focus – but the current financial situation is positive in the sense that it is pushing the higher tier authorities. They have set up some Health and Wellbeing boards.

He also pointed out that, in his experience, patients are unconcerned with who the care deliverer works for, and that the patient needs and wants an integrated service.

Roundtable discussion

Culture change

An officer commented on their council's experience of trying to integrate. The mind-set within their council has been to try to carry out services in an integrated way, rather than changing behaviour. They said that there will always be areas of the service that are outside of the integrated team, but

services should still to be working in an integrated fashion. Changing the culture and behaviour is particularly important and the Integration Transformation Fund (ITF) is meant to solve this problem.

Another officer commented that changing the culture is more important than the ITF itself. It's a big problem that officers, GPs and others involved in delivering integration are taught to work in silos – but that this is slowly changing.

They commented that difficulties with achieving integration are down to people involved in care not taking responsibility, and not being coordinated. For example, an issue can often be passed between different organisations rather than being dealt by the first organisation contacted.

Defining integration

An attendee raised the Kings Fund's recent survey of Health and Wellbeing boards, which was optimistic about the growing trust between clinicians and CCGs. They also questioned what integration means: whether it's an informal approach emphasising cooperation, or whether it means something more formal, such as joint commissioning? They commented that integration can't only be a structure and that in each locality it needs to respond to all kinds of different relationships. This means that the approach is bound to be piecemeal, so sometimes a certain type of integration is better.

Another attendee commented from their perspective as a carer, rather than as a care professional. They gave the example of their ninety-five year old mother, who has dementia, and commented that integration to them meant that the people caring for their mother - the social workers, the nurses etc. - communicate with each other about their mother's needs. It is irrelevant if those delivering the care are in the same team, have the same employer or operate under the same structure, as long as there is effective communication between them.

One attendee commented that everyone has a slightly different perspective on what integration is. They described a charity called Whizzkids, which ensures that children receive wheelchairs that meet their

particular needs. The charity has a very person-centred approach.

Recognising financial pressures

Duncan commented that hospitals have had to change dramatically because of financial pressures. People trust local authorities over central government. There is a challenge around building trust between the Department of Health and the NHS.

Another attendee commented that they felt that the public did not fully appreciate the extent of the financial pressures councils and the public sector generally are under, and questioned how to get that message across.

Leadership on integration

They commented that aspiration, leadership and a sense of ownership are needed to create a culture where innovation can flourish. Networks are the first to engage when change happens. Integration should be focused on local ownership and spending money with a shared sense of ownership and leadership. This will produce better outcomes than changing the structures: it's not what you do, it's the way you do it.

An officer commented that the challenge to Health and Wellbeing boards is to show leadership on acute hospitals, in order to ensure that acute trusts close beds to release money.

Duncan commented that the role of local authorities is to ask the right questions. The right questions are not around how we meet these outcomes, but around who can best meet them.

A representative from the Department of Health commented that they were unsure whether the department is having conversations around integration, and commented that this is a system leadership issue. It's not the role of the Department of Health to tell the sector how to deliver integration.

Integration requires flexibility and adaptability

An officer commented that there are issues around the way the people working in local government are trained. The focus is not on resilience or adaptability and it should be. Local government needs to train people to understand that there will be constant

change. That's one of the biggest areas we need to focus on.

An attendee commented that local government needs to be more robust, so that if one part goes down, it doesn't bring all the parts down.

Duncan commented that the focus shouldn't be on closing hospitals; it should be on how we use what we've got. He felt that acute hospitals stopped closing beds because they stopped believing the commissioners could handle demand. There is something about not giving and taking away, but not giving in the first place.

An officer noted that the sector need to be adaptable, but also have humility. We should not continue to do things in a certain way just because that's how they've always been done.

Next steps

Dr Tony Martin recommended that attendees meet with their CCGs, if they are not meeting with them already. He warned that the sector will not be told how to deliver by the government, and that part of the public sector has this space to move and develop.

An attendee commented that there needs to be a basis of evidence before people will take any risks. The Kings Fund survey was interesting in terms of tensions within the role of Health and Wellbeing boards. The boards have certain responsibilities but there is some uncertainty about what their primary role is, and whether they should get involved in the big issues, like reconfiguration. Their role will be clearer in the coming years.

An officer commented that the dearth of a vision around adult social care, let alone integration, means the sector is visionless, and that at some point there needs to be conversations with CCGs about what integration looks like.

Jonathan concluded the roundtable on a positive note, commenting that in the past, local government had had a considerable impact on public health through the provision of clean water and improved sanitation. He looked forward to the sector reclaiming this place-shaping role.


MEARS

Workforce Issues
24th February 2014

This roundtable explored workforce issues in adult social care. Speakers included Alan Long, Executive Director of Mears Group, who gave the provider perspective, Lyn Romeo, Chief Social Worker for Adults, and Helga Pile, UNISON National Officer for Social Care. Jonathan Carr-West, Chief Executive of LGiU, chaired the event.

The roundtable focused on what a high quality care workforce looks like, how can we achieve it and what the barriers are; what form of contract best achieves a high quality workforce and what type of commissioning will result in a high quality workforce; and what sort of skills we expect from a high quality workforce.

Presentations

In his introductory presentation, Alan Long, Executive Director of Mears Group, explained that Mears believes that to achieve happy customers, you have to start with happy employees. Mears is looking to tackle terms and conditions, meaning not just pay but the whole package.

Alan noted the high profile of workforce issues in adult social care in the media. Issues in the headlines include zero hours contracts, payment for travel time, lack of training, high churn, and lack of progression potential, benefits or pensions. He argued that those criticisms were largely valid, and that providers, local government and central government share the blame.

He noted that the requirements on care workers has never been greater. Care workers must have a clean criminal record, a caring attitude, additional training, be able to drive and have their own transport, and be able to look after those with increasingly complex needs. Care workers also have an extremely stringent performance management assessment, given safeguarding.

Alan argued that part of the problem is councils' tendency to commission by the minute, leading providers to pay by the minute, although a few authorities take a really strategic view, and see care work as a potential career opportunity.

However, Alan felt that the rise in apprenticeships in adult social care suggests action on this issue, and gives the signal that there is a career to be had in care, which will help to build a sustainable workforce. He also praised the rise of outcome-based thinking.

Helga Pile, UNISON National Officer for Social Care, gave a presentation outlining some of the issues around terms and conditions for social care workers. Some of the issues around commissioning includes driving down costs to balance books, reverse e-auctions, maximum prices for homecare as low as £9/hr, scaled back contract monitoring, spot purchasing and the demise of in-house capacity.

Helga then outlined the impacts that this can have on the workforce: a lack of time to care, low pay and falling pay, zero hours contracts which result in financial vulnerability and can be used as a tool of control, long, gappy and uncertain hours, anti social hours, a lack of training, low status, women's work, and a lack of career prospects.

She said that the impacts this can have on users include: high staff turnover with no continuity, lack of reliability, and care can be undignified and rushed. It can also send the message that service users are undervalued by society.

Helga also drew attention to issues around the National Minimum Wage amongst care workers. She stated that 200,000 care workers are not paid the NMW and HMRC reports 48% non-compliance. In addition, travel time can often be unpaid.

However, there are a growing number of councils which have signed UNISON's Ethical Care Charter, including Islington, Southwark, Lancashire and Wirral, with more in the pipeline. They have committed to a quality workforce, which includes: the living wage and income security, more time and more autonomy, ongoing training, supervision and personal development, greater unionisation, mentoring, buddying and peer support and recognition for the important work they do.

Helga finished her presentation by outlining how we move forwards. She argued that

the sector needs more money, the living wage needs to become the floor, they need to work in different ways, they need to recognise that collaboration is more effective than competition, that care workers and service users together need more in control, and that care workers need to be networked into local health and social care teams.

Lyn Romeo, Chief Social Worker for Adults began her presentation by outlining the context of social care work in the UK: there are 17,000 workers registered, 2,000 are employed by NHS, and there are 88,000 registered social workers.

She outlined safeguarding as a priority, and that the sector needs professionally qualified social workers. She argued that commissioners have a leadership role and a responsibility to commission well, focusing on personalising care and support whilst taking positive risks, and working creatively with providers.

She also outlined that fact that there will be an increasing need reflecting the greater numbers of people with dementia and increasing incidences of domestic violence. Mental health is also a key area.

Roundtable discussion (facilitated by the LGiU)

Encouraging graduates to consider a career in social care

One attendee noted the importance of a salaried workforce, to attract both apprentices and graduates. There's an expectation in some authorities that staff will become salaried, but this is still difficult to achieve. A massive culture change is necessary as a result of the huge hierarchy between operational staff and providers.

Another attendee argued that longer contracts with fewer providers came about through consultation with providers who are able to recruit over a longer period of time. They also noted that moving from hourly rates to salaries will take a long time.

An attendee argued that the sector needs graduates to consider social work as a career of choice, rather than career of last hope. A more positive attitude can be seen developing around social work with

children, but less so in adult social care. They also noted a lack of recognition that the sector will need to plan at least 10 years ahead to grow the workforce they need and develop frontline leaders.

One attendee said that the sector doesn't promote or publicise the complexity and intellectual stretch of the work, and the soft skills that are needed, such as how to deal with family dynamics. They argued that the sector needs to claim back that territory, and that this tendency to undervalue the work reflects how we as a society view older people.

One attendee noted that there are two strands of work in adult social care – professional social workers and the care provider side. It's important for the sector to develop and promote a range of possibilities so that, for example, frontline workers can eventually run their own care agency.

The sector has not been good at telling a story about the opportunities within the wider social care sector.

Another attendee felt because social care jobs don't require or ask for a degree, this devalues the work in the eyes of graduates. Therefore the answer could be a graduate scheme which makes it clear that the job is for graduates.

Better Training Needed

One attendee argued that homecare staff are often promoted within the organisation, but are not given management training. On the other hand, they felt that if the sector offers graduates the management roles, this removes the incentive for frontline workers to work upwards.

Society's attitude to older people has a negative impact on their quality of care

One attendee argued that the current debates in adult social care are symptomatic of a broader discourse around how society views and treats people who use services, such as benefits. This must be used as a starting point to ask why services aren't properly funded, and suggests reasons for these problems in social care and the problems around recruitment and retention. The attendee argued that we need to shift that dominant paradigm.

Need to promote the sector as values-driven and skills-based

One attendee said that the sector needs to tell a story around the soft skills needed for adult social care, in order to attract the best people. This includes the ability to build relationships and good communication skills. This must also include value-based recruitment, where the sector seeks out people with the right values and right attitudes.

One attendee argued that we are in a reductionist era in which the work has been reduced to transactions between professional social workers and frontline workers, and another felt that the original care management model, predicated on having a team to work with, has become so scaled up that the work has now just became a process.

Improving terms and conditions

One attendee noted that without the right terms and conditions, the sector won't attract workers with the right values.

Another attendee argued that the attitude of commissioners has a knock-on effect on the quality of work and the attitude of staff. If commissioners treat providers poorly, then this impacts on how staff view care and leads to poor outcomes. Conversely, better pay encourages better outcomes.

Barriers to progress

One attendee argued that the system doesn't fully utilise the skills that social care workers already possess, and that suggesting that lack of training is a barrier is actually a red herring. They argued that coproduction between the NHS, social care workers and providers is needed. The key to improving the system around people could be the social care sector working with GPs.

Importance of social work leadership

Another attendee argued that without social work leadership, the sector will take its lead from the NHS. They worried that this could result in users being placed in residential care when there is no need.

Difficulties around commissioning for outcomes

One attendee stated that commissioning for outcomes has always been a big challenge. When dealing with a single

person it's much easier to consider outcomes, but as soon as a provider has to start balancing large numbers of users against limited time, the logistics make an outcomes-focused approach challenging.

Another attendee argued that often relationships in adult social care can appear as transactional or task-based, when actually the work is centred around relationship-building. They argued that we need to get away from an attitude which sees people in receipt of a service as a drain on resources or without value.

Another attendee felt that, with at least the minimum wage and salaried work, in addition to better integrated health teams, the direct payments programme will begin to work better.

However, another attendee noted that with direct payments there is a danger of fragmentation, and that workers can feel very cut off, which can create a lot of problems.

There was a consensus that the sector needs to change attitudes around what care is, and embrace the idea that sitting and having a chat with people is something worthwhile – and that will also save you money.

The potential of emergent community models

One attendee noted that there are many examples of successful small-scale service provision, such as Community Catalysts, the Connected Care model, Shared Lives plus, TOPAZ in Lambeth. Commissioners need to start realising that emergent community models work. However, they felt there is still a need to convince commissioners that this is a good option, and that it's possible to stop commissioning in minutiae and free providers up to, for example, have a coffee in the pub with a user.

Issues around the integration of social care and health

Another attendee argued that it's a challenge for commissioners to commission creatively. They argue that this is partly due to pressure on budgets, but also partly because social care commissioners are working in an integrated team where they are earning a fraction of what the health

team members are earning. The social care team is leading, but the health team is in position to override.

Another attendee felt that the Care Bill provides the opportunity to see health differently, in a much broader way. They argued that politicians, members, providers and the market, amongst others, have a role in promoting health being seen in a different way.

One attendee made the point that when a community has acute needs these needs are very high-profile. But when a community has a high level of wellbeing and is functioning well, it looks like nothing is happening. Often this represents the difference between the work of social care and health.

One attendee made the point that a lot of workers in health and social care do similar work, and so there is an argument for more joined up training. For example, a lot of social care is similar to nursing.

Difficulties around evidence and quantifying data in social care

The point was made that often understanding the outcomes of neighbourhood community working requires faith, since evidence is difficult to come by or to quantify. You often cannot identify a correlation with improvements. This can be difficult for some.

Moving forwards

The Chair asked attendees what they would change about the sector if they could change one thing:

- Another attendee said the sector needs to get better at evidencing performance and how much things cost, and that it's possible to have a model around risk and rewards and quantifying things.

- Another attendee argued that the sector needs to start commissioning for the relationship and not for the task.

- A final ask was that, if providers are to work in a personalised way, commissioners need to be allowed to work creatively with the user.

The LGiU is a think tank and local authority membership organisation. Our mission is to strengthen local democracy to put citizens in control of their own lives, communities and local services. We work with local councils and other public services providers, along with a wider network of public, private and third sector organisations.

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