Nottinghamshire County Council

Feedback Form
Caring For Our Future: shared ambitions for care and support

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

a. Should there be a standard definition of quality in adult social care as quality can often be interpreted differently? What do we mean by it and how should it be defined? How could we use this definition to drive improvements in quality?
b. How could the approach to quality need to change as individuals increasingly fund or take responsibility for commissioning their own care? How could users themselves play a stronger role in determining the outcomes that they experience and designing quality services that are integrated around their personal preferences?
c. How could we make quality the guiding principle for adult social care? Who is responsible and accountable for driving continuous quality improvement within a more integrated health and care system?
d. What is the right balance between a national and local approach to improving quality and developing the workforce? Which areas are best delivered at a national level?
e. How could we equip the workforce, volunteers and carers to respond to the challenges of improving quality and responding to growth in demand? How could we develop social care leadership capable of steering and delivering this?
f. How could we improve the mechanisms for users, carers and staff to raise concerns about the quality of care? How could we ensure that these concerns are addressed appropriately?

a. Good quality care will be determined by the individuals who receive the care, their families/carers and advocates where the individuals themselves lack capacity. Providers of social care services should be required to evidence how they ascertain the views of the person receiving the care service. They should also be required to evidence how this feedback is being used to inform the nature of the service and the ways in which it is being provided to the individual receiving the care, and how this is meeting outcomes.

b. Information, advice and support should be made available to people who fund and/or commission their own care and their family/carers so that they know how they can make their personal preferences known to the care provider.

c. It is right that quality should be the guiding principle in adult social care – this is incorporated in to measures that are in place to safeguard vulnerable people and promote the dignity of those people who access care services. It has to be the responsibility of the local authority and health commissioners as well as the providers of health and social care services to drive quality improvements. Where there is a contract with a care provider, that contract should identify explicitly what role the local authority and/or health commissioners will play in driving quality improvements and what is expected and required of providers.

Where services are provided by voluntary and community organisations or micro providers, it would help if local authority and health commissioners have a process for accrediting the providers which would need to include regular quality audit and review processes. This should predominantly consist of self assessment similar to the QAF used in Supporting People funded services. It is vital that such processes do not create barriers to entry in to the social care market or create unnecessary bureaucracy, but they are required in order to ensure non regulatory services are quality monitored. It is essential that the right balance is achieved to encourage a wider range of services and ensuring they are of good quality.

d. National Minimum Standards for regulated services provide a framework for good quality care for regulated services. It would be helpful to have a similar nationally defined framework for non regulatory services, with an emphasis on safeguarding and dignity. However, such service provision need not be regulated at the national level. It would be reasonable to expect local approaches to improving quality and for the development of the workforce. However, local authority and health commissioners will require sustained funding to ensure continuous workforce development and improvement. In Nottinghamshire, the Workforce Development Grant has been vital in supporting the training of the social care workforce and we are able to evidence where quality has improved through the use of the grant. There should be a local approach to improving quality and developing the workforce, however this will only be rigorous and effective if local authorities and health commissioners are allocated specific funding for this purpose.

e&f. Health and social commissioners need to take a proactive approach to market development in order to meet the growing demand for services. A positive and mature relationship between commissioners and social care providers is critical. Providers will grow and will develop their services if they are informed about commissioning requirements and intentions. However, as personalisation becomes better embedded, providers need to take a more proactive role in determining and shaping their services to meet the needs of people who want to commission services directly.

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

a. How could we change cultures, attitudes and behaviour among the social care workforce
to ensure the benefits of personal budgets, including direct payments, are made available
to everyone in receipt of community based social care? Are there particular client groups
missing out on opportunities at the moment?
b. What support or information do people need to become informed users and consumers
of care, including brokerage services? How could people be helped to choose the service
they want, which meets their needs and is safe too? How could better information
be made available for people supported by public funds as well as those funding their own care?

c. How could the principles of greater personalisation be applied to people in residential
care? Should this include, as the Law Commission recommends, direct payments being extended to people [supported by the State] living in residential accommodation?
What are the opportunities, challenges and risks around this?
d. How could better progress be made in achieving a truly personalised approach which places outcomes that matter to people, their families and carers at its heart? What are the barriers? Who has responsibility and what needs to change (including legislative)?

a. In some areas of services such as learning disabilities, legislation has helped ensure that services are person centred and focussed on meeting an individual's specific needs. In Nottinghamshire, people with physical disabilities have for some time now been using direct payments as a means of meeting their needs and achieving their outcomes - whilst this has taken some time to achieve, there are clear expectations that services provided to people with physical and or learning disabilities are person centred and outcome focussed. This has not been the case for services provided to older people where, historically, community based services have been commissioned in a more prescriptive way via contracts with providers.

Given the nature and volume of services, it will take time to implement personalisation within older people's services. The approach has to be two fold:

- people who use services and their families/carers need to be informed of the options that are available to them so that they can make meaningful choices about how their care is provided and be able and willing to manage risks that come with directly arranging and managing care and support services
- providers need to be helped and supported to provide individualised care which is based on the outcomes identified by the person receiving the service.

b. Contractual arrangements with providers need to reflect the move away from standardised, time and task services, to those that are based on the individual's desired outcomes. Health and social care commissioners need to help develop a market of social care services which is not only informed by but also led by the outcomes identified by the people who access the services.

Timely and accurate information, advice and support services are critical in enabling people to choose the services they require – the development of local initiatives such as 'Shop 4 Support' will help both self funders and people who want to commission and manage their own care services. Local authorities and health commissioners can help ensure that people are able to explore the options available to them, and also the range of services they are able to access. Making informed choices means that people who access services and their families/carers are made aware of and equipped to manage any risks. Accreditation processes such as traders' registers and 'buy with confidence' will help with this.

c. Personalisation can be implemented within residential care especially where an individual requires one to one support. Day time activities, entertainment etc can be tailored to meet individual needs and could be purchased through direct payments. Board and lodgings, or 'hotel costs' could be fixed and the services provided could be purchased flexibly via an individual's personal budget allocation.

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

a. What does good look like? Where are there good practice-based examples of integrated services that support and enable better outcomes?
b. Where should services be better integrated around patients, service users and carers – both within the NHS, and between the NHS and local government services, in particular social care (for example, better management of long term conditions, better care of older people, more effective handover of a person's care from one part of the system to another, etc)?
c. How can integrated services achieve better health, better care and better value for money?
d. What, if any, barriers to integration should be removed, and how can we incentivise better integration of services at all levels?
e. Who needs to do what next to enable integration to be progressed in a pragmatic and achievable way?
f. How can innovation in integrated care be identified and nurtured?

a. Good services promote independence and person centred care, they support risk taking in a managed way and regularly review their own activity in an effort to improve and move forward.

b&c. Services could and should be more integrated between health and social care especially services or interventions that prevent unnecessary admission to acute or long term care. There could be greater integration between social care reablement type services, intermediate care and rehab services. Other areas that could be better integrated are acute and community or primary care services in the NHS - there are opportunities for more joint services and improved pathways for services users who can sometimes get lost in a labyrinth of different services and processes. There are some good examples of joint working between health and social care but these are more often discreet services or projects. There needs to be consideration given to whether this is the best way to achieve good outcomes for service users or whether whole scale integration would be better.

d. Barriers still remain between health and social care in terms of philosophy, ethos and culture, IT systems and record keeping, budget and the way services are accessed i.e. free access or eligible and charged for services. We spend too much time thinking about who pays for what and this acts as a barrier to working closer together. The issue of charging for social care in residential and nursing homes but not for health care needs to be addressed. Separation between what is board and lodgings and what is healthcare/social care support would need to be better managed.

Disincentives regarding existing tariff payment systems need removing. The Payment by Results models emerging in Mental Health services risk introducing perverse

incentives that maintain very high cost services and offer little reward for low cost preventative approaches.

e&f. Moving Public Health into Local Authorities and the development of Health and Well-Being Boards is a welcome step forward and will provide opportunities for much more joint working, shared agendas and will help foster a greater sense of joint ownership of problems and solutions.

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

a. What do good outcomes look like? Where is there practice-based evidence of interventions that support/enable these outcomes?
b. How could organisations across the NHS and Local Government, communities, social enterprises and other providers be encouraged and incentivised to work together and invest in prevention and early intervention including promoting health and wellbeing?
c. How could we change cultures and behaviour so that investment in prevention and early intervention is mainstream practice rather than relying on intervention at the point of crisis? How could we create mechanisms that pay by results/outcomes?
d. How could individuals, families and communities be encouraged to take more responsibility for their health and wellbeing and to take action earlier in their lives to prevent or delay illness and loss of independence? How could we promote better health and wellbeing in society?
e. How could innovation in prevention be encouraged, identified and nurtured?

a. Good outcomes ensure:

- Vulnerable people feel safe and protected
- People are less socially isolated and have strong social networks
- People have access to accurate, credible and up to date information
- People are engaged in their communities and with supporting others if appropriate
- People are engaged in volunteering, paid work or other activities that increase self-esteem and their incomes are maximised and their debt managed

Locally there is evidence to support these outcomes. It would be extremely helpful if greater emphasis and requirement was placed on qualitative data and evidence of good outcomes through national performance requirements and was perceived as important as other performance measures. This data may include quality of life measures and other measures which focus on how outcomes are being met rather than counting outputs.

b. Better partnership working requires effective leadership and engagement through the Health and Well Being Board. We must make the most of the opportunities created by Public Health joining Local Authorities. We need to develop shared visions and strategies and better partnership working. We would benefit from

research into the effectiveness and efficiencies of prevention activities that can measure quality of life, `added life years' and cost effectiveness.

We need to consider pooled budgets from health, social care and employment support to promote opportunities possibly using the Community Fund holding option to create synergies between individuals and coordinated community action.

c. There is a need for joint training with partner agencies, co-working on shared projects, use of research and other examples of successful projects to change culture and attitudes towards prevention. As mentioned before, strong leadership is needed from Health & Well Being Boards downwards, in order to encourage and reward preventative ways of working.

d. We need to adopt ways of working, through staff trained and briefed on prevention models, which empower people. We need to be better at sharing good practice and engaging with members of the public to involve them in the conversation about the importance of prevention. We need to pursue more projects such as peer mentoring, adult education, and schemes such as time banks, skill swap, and reciprocal help - the 'Circle' model from Southwark.

e. To encourage innovation in prevention we need strong leadership which encourage and reward preventative ways of working. Through market development activities, we need to encourage and support innovative services and increase the number and range of micro providers who have ambition but may need help with initial set up. We need to value performance measures which relate to quality of life rather than activity levels.

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

a. How would you define the social care market? What are the different dimensions we need to consider when assessing the market (e.g. type of provision, client group, size of provider, market share)?
b. How could we make the market work more effectively including promoting growth, better information for commissioners (local authorities and individuals), improved quality and choice and innovation?
c. Does there need to be further oversight of the care market, including measures to address provider failure? If so, what elements should this approach include, and who should do it?
d. Looking to the future, what could be the impacts of wider reforms on the market? What possible effects would the following have on the market: the recommendations of the Dilnot Commission's report, the roll out of personal budgets and direct payments, and the drive to improve quality and the workforce?

a. Historically, local authorities and health commissioners have purchased services through block contracting arrangements. This gave providers a degree of financial security for the duration of the contract term and they had clear expectations placed on them through the service specifications and the contractual terms and conditions. However, this has had many limitations as it resulted in the provision of very prescriptive services which prevented innovation and personalised services.

In implementing personalisation, local authorities have begun to move away from block contracting arrangements, to using framework agreements in order to free up budgets to allocate to individuals as direct payments. Providers are being required to be more flexible in the services they provide and to enable individuals to commission services directly. This model results in less financial security for providers at a time when they are being asked to be more innovative and flexible in the range of services they offer. Local authorities are also placing demands on providers to deliver greater value for money in order to maintain service levels whilst there is escalating need.

b. One of the main factors preventing sufficient growth in the social care market to meet demand has been the difficulty in recruiting and retaining sufficient care workers. Government both at the national and local level needs to ensure that all is done to increase the number of people who take up a career as care workers, health care assistants and PAs. Alongside this, more could be done to increase the profile and role of voluntary and community work.

If the social care market is to be supported to develop and expand, then local authorities have a key role to play in providing information and support to providers about the range of services that are needed. The market also needs to include a more diverse range of providers including micro providers who have local intelligence about the types of services required within the communities where they are based. New and evolving businesses need information, advice and support in relation around setting up and getting a social care business started including provision of funding to support this. Additionally, support with training for social care staff is essential to ensure good quality care and longer term sustainability.

c&d. Oversight of the market is required at the national level particularly for regulated services, and there should be a responsibility on providers to ensure they are providing good quality and financially sustainable services. Local authorities and health commissioners should have a key role to play in ensuring there is a viable market of provision and in addressing provider failure. The measures need to be proportionate so that limited resources are targeted at those providers where there concerns about quality of care and/or about financial viability.

As increasing numbers of people begin to commission their services directly from providers and the local authority's purchasing power is reduced, it is all the more imperative that providers are held to account for good quality provision and for financial security and stability. It would be very helpful to have a requirement for the national regulatory body to work much more closely and collaboratively with the local authority and health agencies to ensure compliance with regulatory requirements and also to hold providers to account in relation to financial viability.

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

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

b. To what extent would the reforms recommended by the Commission on Funding of Care and Support overcome these barriers? What kinds of products could we see under such a system that would be attractive to individuals and the industry?
c. What else could Government do to make it easier for people to plan financially for social care costs?
d. Would a more consistent system with nationally consistent eligibility criteria, portability of assessments and a more objective assessment process support the development of financial products? If so, how?
e. Would the reforms recommended by the Commission on Funding of Care and Support lead to an overall expansion of the financial services market in this area? How would this affect the wider economy?
f. What wider roles could the financial services industry play in, eg:
– raising awareness of the care and support system
– providing information and advice around social care and financial planning
– encouraging prevention and early intervention
– helping people to purchase care, or purchasing it on their behalf
– helping to increase the liquidity of personal assets?

a. Currently, there seems to be an emphasis on financial products that can result in avoiding paying for care fees rather than supporting clients to make provision for their future needs, as is the case with private pensions. There is still the viewpoint that the state will provide which does not stimulate the development of financial products to meet care costs. There has also been negative media coverage of cases where pensioners have taken up Equity release schemes to provide them with sufficient income in retirement which have resulted in them falling into debt or being evicted from their own homes.

b. More affordable care insurance policies and increased awareness of the costs of providing care will prompt more people to consider longer term financial planning up to and throughout retirement. Products that allow ongoing contributions to insure income for future care needs may be more widely attractive than products that require capital investment. Bonds, which are currently purchased with a life interest, could be tailored to pay out in the event of care being required. Insurance products could be linked to pensions and NI contributions.

c. There needs to be a much clearer approach regarding the promotion of equity release product take-up. It is recognised that individuals want to remain in their own homes but a cultural shift needs to be encouraged nationally so older people start acknowledging that they will need to utilise their equity in order to support their aspirations. Government clearly promoting the take up of specific equity release products would facilitate this process. Benefit would also come from solicitors and estate agents being trained in the specific needs (technical knowledge/ communication styles etc) of older people with regard to equity release, down sizing etc.

d. A more consistent system would end the perceived 'postcode lottery' and ensure a transparent provision for those in need.

e. By capping the amount that an individual will pay in total towards their care costs, this will stimulate the financial sector to provide products that can be marketed more

positively with a better take up rate. Government and insurance market would need to ensure that insurance products are simple, accessible and well publicised to ensure that buying them becomes the norm rather than the exception.

f. Financial Services will have an important role in advising people to contact Social Care services for an assessment of their needs where applicable, to ensure that people receive the right level of care at the right time and preserve their financial resources for as long as possible. Raising awareness of the cost of care to the individual but also being clear on the cost of any products purchased and the different options available dependent on individual needs.

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

a. What are the strengths and weaknesses of the Commission's proposals in addressing the problems of the current system? What are the priorities for action coming out of the Commission's report, including in relation to other priorities for improvement in the system?
b. What are the implications of the Commission's proposals on other areas of care and support reform?
c. The Commission presented a range of options in relation to some of their recommendations, which would affect the balance between the financial cost to the individual and the taxpayer. These include:
• the level of the cap
• the contribution that people make to their living costs in residential care

What would be the implications of different options on the outcomes that the Commission hoped to achieve?

a-d). In Nottinghamshire, adult social care is approximately 44% of Council expenditure in 2011-12. Based on the figures in the Commission's report about funding required to meet future demographic needs, Nottinghamshire would need an extra £100-£125m by 2025 on top of the net budget of £219m; taking adult social care spending to around 70% of Council expenditure. This is unsustainable.

Currently the Authority is making £180 million savings over a four year period. This includes finding an extra £10 million of additional funding annually just to meet the extra pressures on our services caused by people living longer. In Nottinghamshire, 550 residents each year are turning 85. Many of these people have dementia and the related cost of appropriate residential care can range from £650-£1000 per week.

The Council believes that we can no longer continue with the way we currently fund care for vulnerable people, and that there is a significant risk that the current funding system will not be able to meet people's needs appropriately. Often care and support is required in times of crisis and people then tend to make uninformed and hasty decisions, because they have not previously planned for their future care needs. The Commission's proposals, in the introduction of the cap, offer the opportunity to come

up with alternative provision which will ensure people are better prepared and protected in times of need.

A motion on the issue of social care for older people and people with disabilities, and how it should be funded both now and in the future was discussed at the full Council meeting on 3rd November. There was a unanimous vote of support for the motion, which was as follows:

“That this Council:

- supports the current national debate prompted by the Dilnot proposals on how to achieve a fair, affordable and sustainable system for funding adult social care;

- welcomes the Secretary of State’s announcement of a further period of consultation and a White Paper due for the Spring;

- asks Parliament to consider the Dilnot proposals carefully and fund local government properly in the context of the current public spending environment.”