

Market Sustainability Engagement and Research Findings

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Introduction

Recent publications have highlighted that at the national level the sustainability of the ASC market is increasingly at risk. Following on from these recent discussions at North-West Association of Directors of Adult Social Services (NW ADASS) Branch meetings focused on the scale of financial challenge and the level of risk in care markets in the North-West. This has led to the Branch asking:

- How well does the Region and Sub-Regions within it understand these risks and challenges? In particular the financial challenge and
- What commissioning and market oversight arrangements by individual LAs, sub-groups of LAs and by the Region, as a whole, would best mitigate these risks? How are existing markets for older people's and learning disability services constituted?

To help answer these questions the NW ADASS Region asked Alder Advice to use data available within the region and nationally, and to engage with commissioners and providers within the Region, to advise it on its future approach to commissioning and market oversight.

Alongside the financial and activity data that was analysed to form much of this report, we wished to gain an overview of the regional social care market from providers and commissioners. The project did not include connecting with service users.

Our aim was to canvas views on the key issues facing the social care market in the region, to consider which issues were most critical and, crucially, to explore innovative ways to address them in moving forward.

We developed a methodology that explored the twelve key issues in detail. This started with an online survey, followed by eight engagement workshops and seven in-depth one to one interviews. Views were triangulated through secondary research and ultimately ideas for innovative ways forward were generated.

The Issues

Referencing the House of Commons Select Committee Report from 2017 on the adult social care market, we identified 12 key issues to explore with stakeholders.

Survey:

An online survey, open to all providers and commissioners, was conducted across the region. Over 100 people completed the survey. This section presents an overview of what the most pressing issues are in the region, and what respondents feel about them via a comments section.

Workshops: Pairs of workshops (one for providers and one for commissioners) were held in four sub-regions of the area; Liverpool City Region, Warrington and Cheshire, Lancashire and Cumbria, and Greater Manchester.

Interviews:

Additional interviews were held with seven key stakeholders from across the region including NHS staff, employer groups on finance, performance and contract management, and Skills for Care.

These interviews gave additional perspectives to those collected via the survey and the workshops. The points made at the interviews are included in the workshops section of this appendix and are not separately attributed.

Secondary Research:

Wherever possible we have attempted to support views and ideas expressed through the survey, workshops and interviews with secondary research. Section 4 of this appendix collates some of these findings.

Innovation: Moving On:

Innovative ideas and experiences from the survey and workshops, together with information gathered from the stakeholder interviews and secondary research, have been pulled together around the twelve issues to produce a menu of innovative responses. We hope that Directors across the region will be able to take this section and develop action plans appropriate to their own situation and circumstances.

Section 1: The Issues

There has been no shortage of national and local debate on the troubles and uncertainties experienced in the adult social care market over the last ten years. The lack of a clear national lead, with proposals accepted then rejected, has helped to create the most difficult of landscapes for commissioners, users and providers to navigate.

We have chosen the House of Commons Communities and Local Government Committee report on Adult Social Care, published in March 2017, as a basis for the 12 issues that formed a cornerstone for our work. The report was up to date and covered pressure points that were important to commissioners, providers, service users and politicians. This was not just a technocratic trawl through the field, but rather a consideration of issues that were important to people using and purchasing the services.

The 12 issues, and why the Committee considered them important are summarised below.

1. Highest Needs Priority:

Councils are providing care and support to fewer people and concentrating it on those with the highest needs. The implication and consequence being that those with lower levels of need are receiving reduced or ceased services.

2. Care Provision – Minimum Level:

Care provision is starting to be provided at the minimum level required for a person to get through the day. The implication being that even those people who do receive services are likely to get a reduced amount of care.

3. Care Quality Deterioration:

There has been a deterioration in the overall quality of care, which is likely to continue. This issue is very hard to quantify and easy to challenge. It does however reflect a nationally perceived and debated situation.

4. Provider Failure:

Serious threats to the financial viability of care providers, with providers failing, exiting the market and handing back contracts for provision of care services. For commissioners this can present considerable logistic difficulties. For providers it can be an existential crisis. For service users it can be a loss of stability and a home.

5. Cross Subsidy:

Reliance by care providers on private clients (paying higher fees) to subsidise local authority funded clients (paying lower fees). A bit of a dark art that has huge potential for disruption if picked up nationally by the media.

6. Market Shaping:

Councils are finding it difficult to shape the care market to provide diverse and high-quality care for all people in their area. Demanded by the Care Act, the building of good working relationships with providers and voluntary groups is probably crucial to success in this area.

7. Fee Setting:

The approach to setting care fees has become the driving factor in commissioning for many councils. Financing fee increases to stabilise the provider market, and paying for increasing needs will be challenging. The potential for destructive adversarial relationships between commissioners and providers is both high and crucial to avoid.

8. Workforce Challenges:

There are severe challenges in the care workforce, manifested in high vacancy and turnover rates. Recruitment, retention and career pathways are all difficult to sustain for employers.

9. Reliance on Unpaid Carers:

Unpaid carers are providing more hours of higher-level care as councils have reduced provision. An inevitable consequence of reduced provision is not necessarily a bad thing for service users.

10. Carers' Needs:

Councils struggle to fulfil their statutory duties to identify, assess and meet carers' needs for support. Is this the inevitable early casualty of funding pressures?

11. Hospital Discharge:

There have been increases in emergency admissions into hospital and delayed discharges from hospital. A huge issue for the NHS and social care; but is it also central to the adult social care market?

12. Social Care & Health Integration:

Social care and health integration is not as good as it could be. Integration can take place, or fail, at many different levels between the two areas of organisation and provision.



Section 2: The Survey

The online Survey (platformed on Survey Monkey) was a quick-fire list of questions asking respondents how important each of the 12 Issues are for their organisation.

There were five possible responses:

NON-ISSUE

LOW LEVEL

MEDIUM LEVEL

HIGH-LEVEL

CRITICAL

For each issue, there was also an option to comment in free text. Providers and Commissioners were invited to complete the survey during June and July 2017. Over 100 people responded. This was gratifying.

Of the 108 respondents:

- 81% were Providers
- 19% were Commissioners

Respondents were also asked which client group they worked with:

- 49% worked primarily with older people.
- 36% worked with both older people and people with learning disabilities.
- 17% worked primarily with people with learning disabilities.

The aim of the survey was to find out which of the 12 issues ranked as most important to the respondents. By combining the results from both commissioners and providers a picture across the whole social care market in the region was developed.

We considered it important that the results were not automatically disaggregated as this would be just a continuation of a purchaser-provider split that can be far from helpful.

In this section, we first look at the overall profile of the survey results. Ranking the response, we can see clearly that there is a hierarchy of concern. Each question is then presented with details of the response rates and summaries of key comments from respondents.



The Overview:

By looking at the percentage responses for each option a summary of how critical the issues were ranked by the respondents can be developed. This was used initially to feedback to the Engagement Workshops and is now presented here in a final revised form.

The purpose is to give a broad view of which issues are perceived to be most important in the social care market in the North-West Region:

RANK	ISSUE	SUMMARY RESPONSE
1	Provider Failure	HIGH/CRITICAL
2	Fee Setting	HIGH/CRITICAL
3	Workforce Challenges	HIGH
4	Market Shaping	HIGH
5	Social Care & Health Integration	HIGH
6	Care Quality Deterioration	HIGH
7	Highest Needs Priority	MEDIUM/HIGH
8	Care Provision – Minimum Level	MEDIUM/HIGH
9	Cross-Subsidy of Care Fees	MEDIUM/HIGH
10	Hospital Discharge Delay	MEDIUM
11	Unpaid Carers > Reduced Provision	MEDIUM
12	Carers' Needs	MEDIUM

A repeated comment on seeing these results ran along the lines of “it would be different if it was just commissioner or just providers”. We resisted disaggregating the results; this is one market and the split results would fall into the “interesting” rather than “useful” category.

What the list does show is that half the issues have a higher priority than the rest. This does not diminish the importance of a response to the lesser issues, but it does show where the main concern lies.

The Questions in Detail:

Each question from the survey is presented below, with percentage scores for each response, and, importantly, a selection of the comments section, to give a flavour of the responses. These responses are grouped around:

- Implications for Commissioners.
- Implications for Providers.
- Broader Points.

The issues are presented as ranked in order of importance by survey participants.

Question 1

Serious threats to care providers' financial viability, with providers failing, exiting the market and handing back contracts for provision of care services.

NON-ISSUE	5%
LOW LEVEL	11%
MEDIUM LEVEL	16%
HIGH-LEVEL	34%
CRITICAL	34%

Comments by respondents

Implications for Providers:

- “We have handed back contracts we have had for years because of the financial squeeze from the local authority.”
- “The main threat comes from the further increases to the national living wage and HMRC’s position that each hour of a sleep-in shift should be paid at the National Living Wage.”
- “As a company, we ensure that we have a plan in place to prevent this from happening.”
- “Lack of referrals and unwillingness to pay fees on time along with an ever-increasing workload due to additional quality assurance documentation. Increased cost of training is making it increasingly difficult for non-profit providers to remain financially viable.”
- “Increasing pension and living wage costs with decreasing budgets for health and social care have a massive impact.”
- “To date, the Council has not issued fee rates for 2017/2018, despite an extensive market testing exercise. This increases the financial pressure on providers.”
- “We have approved a deficit budget for the first time in 12 years - and pressures are mounting, particularly with recruitment and retention of support workers and frontline managers.”
- “Our percentage of expenditure on wages has risen these last few years from 50% to 65%. We have been advised to sell as soon as possible because the value will drop to like bricks and mortar only in the next two years.”

Implications for Commissioners:

- “Commissioners make decisions that fail to reflect the actual cost of providing care. They are not committed to developing the market or ensuring its sustainability.”
- “Obviously, a major risk on and above the horizon.”
- “I am currently looking at all contracts and handing back work.”
- “Providers are not tendering for work which has been handed back because it is not viable.”
- “Commissioners need to recognise the need to pay higher rates to providers who provide specialist services of complex cases.”
- “Options are being developed, including caretaker frameworks to address nursing and residential care failure on a large scale.”
- “A lot of recent care home closures, which have been because of quality concerns rather than financial viability.”
- “We are in a different position where we are actively growing in provision, and are looking at other ways to develop as a care provider.”

Broader Points:

- “Increased expectations and regulations from the CQC and infection control, means more money needs to be spent on the care home to maintain high standards. The local authority fees, however, are not increasing in line with this, and therefore a shortfall exists, which would explain why care homes are increasingly struggling financially.”
- “The council risk limiting beds and therefore demand will outstrip supply, resulting in huge increases in prices.”

Question 2

The approach to setting care fees has become the driving factor in commissioning for many councils.

NON-ISSUE	1%
LOW LEVEL	9%
MEDIUM LEVEL	17%
HIGH-LEVEL	42%
CRITICAL	31%

Comments by respondents

Implications for Providers:

- “Living wage sleep-in rates are a real issue when the local authority will not recognise the costs we, as a company, have to bear.”
- “Critical for the future of the business.”
- “For the sixth year in a row, we have been through the same process and completed the same paperwork. The Council has disregarded all the information we have provided because the pre-determined percentage of providers have not responded.”
- “We want to see a fair and true cost of care fees set.”
- “If local authorities do not uplift fees when there is an increase in the National Minimum Wage or legislation changes, it leaves the providers footing the bill from depleted resources until the local authority acts and offers uplifts.”
- “How can such a low offer of 2.84% increase be justified? The increase last year was 3.6%, but the accumulative impact of the National Living Wage this year is far more significant.”
- “Payment can be late and can be problematic. Financial assessments can take months.”

Implications for Commissioners:

- “Sometimes this is done unilaterally and poorly, sometimes done well and collaboratively.”
- “Service transformation is the driving factor and primary aim of most local authority social care commissioning functions.”
- “This is becoming less of an issue, with quality a higher priority.”
- “We are in an on-going dialogue with care providers about financial pressures and operating costs. Finance information provided by local contracted care providers - including details of operating costs, National Living Wage etc. - is used to undertake a finance modelling exercise to develop local hourly rates for fees and charges.”
- “The Council still haven’t increased their fees since the National Minimum Wage increase in April 2017.”
- “We do realise that the current model of support at home is broken. We are working together to develop a new model of care at home.”
- “We need to move past a fee-based relationship to a quality and improvement-based relationship with the market.”
- “We feel that there have been opportunities to consult with our local authority and negotiate fee levels.”
- “CCGs are much more aware of the cost of supporting our customers.”
- “Care fees have been increased on a yearly basis over the last two years to enable providers to meet obligations around minimum wage and pensions.”

Broader Points:

- **“Much effort and time is used in assessing and managing fee level negotiations.”**
- **“The Council has knowledge and understanding of how to run and operate a domiciliary care function that has been lost and, in turn, how much such an operation costs.”**
- **“The race to the bottom for low fees is making services unsafe and organisations unsustainable.”**

Question 3

There are severe challenges in the care workforce, manifested in high vacancy and turnover rates.

NON-ISSUE	6%
LOW LEVEL	9%
MEDIUM LEVEL	25%
HIGH-LEVEL	33%
CRITICAL	27%

Comments by respondents

Implications for Providers:

- “Recruitment is difficult. Contributing factors include the bad press that social care seems to attract and the lack of career pathways for staff.”
- “Pay differentials between support workers and experienced staff have now been eroded.”
- “Not enough staff available. Agencies are using this shortage to charge exorbitant fees. Staff mobility has never been higher. Qualified staff are demanding ever increasing wages or they leave and work for agencies.”
- “Staff turnover is high. We have to put in rewards and pay increases to keep the staff.”
- “Nurses are generally quite difficult to recruit as we cannot match NHS Pensions.”
- “Low morale, poor career prospects.”
- “Paying above the NLW and not funded to do so. Great staff and keeping them is critically important.”
- “Work hard to maintain our retention rates through an in-depth induction and on the job training regime.”
- “Our ageing workforce are undertaking a physically taxing role. Difficult to replace older domiciliary care workers as younger staff (aged 18 -25) are more likely to take up social care jobs within the residential sector - no need to pay for and run a car.”
- “Care sector workforce tend to move around between providers.”
- “High staff turnover leads to repeated induction and training costs.”
- “We don’t find recruitment or retaining staff difficult.”
- “We have an active and responsive HR team and managers and our staff turnover is half the national average.”
- “The reason I do not have a high turnover of staff could be the hourly rate I pay staff.”
- “Staff are having to work to an older age to get their pensions, this leads to an increase in sickness levels.”
- “Geographical - we have greater recruitment and retention problems in more affluent areas.”

Implications for Commissioners:

- “Being addressed through ethical frameworks and collaboration with Providers.”
- “Recruitment is challenging, and we are trying to address this by working in partnership with health to develop viable and attractive career pathways across the whole health and social care economy.”
- “Local authorities should work closer with providers on workforce challenges. We should have monthly meetings and be able to share information when we have care staff that are jumping from one provider to another.”
- “Our upcoming challenge will be the lack of finance to support staff to achieve formal qualifications.”

Broader Points:

- “A lack of recognition nationally of the level of responsibility and nature of work undertaken by care staff each day.”
- “Constant underfunding of social care along with increased government levies and taxes on social care employers and its subsequent impact on the care workforce is entirely foreseeable in terms of causation.”
- “Paying the National Minimum Wage for sleep-ins is a ridiculous waste of public money for going to sleep and needs to be looked at by Government.”

Question 4

Councils are finding it difficult to shape the care market to provide diverse and high-quality care for all people in their area.

NON-ISSUE	11%
LOW LEVEL	9%
MEDIUM LEVEL	31%
HIGH-LEVEL	39%
CRITICAL	10%

Comments by respondents

Implications for Providers:

- “As a provider of services, I find that the communication with the council is very poor.”
- “It is difficult to stimulate investment by providers when there is a lack of funds available.”
- “There is a strong demand and a shortage of providers willing to work at the rates on offer. There is also insufficient supply of some specialist services. There is some likelihood that the problem will worsen.”
- “In our organisation, our focus is on high quality care, however, we would like support to become more diverse to enable our business to thrive.”

Implications for Commissioners:

- “‘Time and task’ contracts are the norm, and the radical changes that are needed to create a sustainable market for social care are not happening.”
- “Councils are clear on what needs to be done to diversify local markets. Challenges to do this include developing a strong community offer of support, but this takes time. Service model transformation needs to take place while also continuing to fund, monitor and effectively manage traditional models. Provider appetite for transformation is low.”
- “Some local authorities have put a lot of work into investing on partnership work with providers and in these cases the market looks and feels very different. This also inspires providers to work together more, creating better outcomes for communities and people.”
- “They are not finding it difficult, they just do not understand the market and have no concept of running a business.”
- “Good relationships and engagement mechanisms with providers have been developed in this area. The work is still in its infancy, but the conditions and infrastructure are there to be able to shape the market.”
- “There is no recognition from local authorities that specialist service exists, it’s head in the sand commissioning.”
- “It is evident that little or no planning to meet current or future needs is on the agenda at present. From a provider perspective, it feels like commissioners are responding in a reactive rather than a proactive manner.”
- “Communication with providers has improved recently. This is helping deal with this issue.”

Broader Points:

- “The fact that they think they can shape it is the problem.”
- “Trying to shape a market to fit a financial constraint will never provide a market that is fit for purpose. Design your market based on need.”
- “I am not sure it should be the local authority that is shaping the market, as this brings things into a more uniform approach. This prevents innovation.”
- “Councils are trying to shape a market with no acknowledgement of market forces.”
- “Shaping the care market is not often apparent; mostly the local authorities are fire-fighting day to day issues.”

Question 5

Social care and health integration is not as good as it could be.

NON-ISSUE	4%
LOW LEVEL	8%
MEDIUM LEVEL	32%
HIGH-LEVEL	41%
CRITICAL	15%

Comments by respondents

Implications for Providers:

- “This is currently a low-level issue that in the main is due to the providers building long term sustainable relationships with all professionals around the person supported.”
- “Always adversarial. There is often a clear boundary between the disciplines and difficult working arrangements are evident.”
- “It is confused and inconsistent.”
- “Delays in funding being transferred between health and social care and the delays in acceptance of responsibility for funding significantly affects our cash flow and vacancies.”
- “It is non-existent locally with service users and families struggling to navigate different assessment criteria to access services or review care needs.”
- “Increasingly problematic to access nursing care reassessment for residents with increasing needs. Lack of joined up services does have an impact on our ability to provide person centred care.”
- “When it comes to a practical level it can take many months to finally agree who is paying for what.”
- “Client access to services is often hindered by disagreements of joint funding.”

Implications for Commissioners:

- “The council has pooled budget and joint commissioning arrangements with the CCG and will continue to develop joint arrangements.”
- “Has been an issue but we have greater integration now so the opportunities are good.”
- “All referrals from both social care and health come through one pathway in our local authority.”
- “We are in the very early stages of working toward Accountable Care System. Work is beginning on how the arrangements will work and what they will focus on (e.g. finance).”
- “The Council has a Strategic Partnership Agreement for integrated all age community health and social care services (Section 75), with the NHS Foundation Trust.”
- “Decision making criteria, pathways and responsibility needs to be made clear and this disseminated to all parties to avoid costly hold ups and the increasing burden of additional time and effort in chasing responsible persons for decision making.”
- “Through improved communication we could offer a more streamlined service.”
- “Some excellent work being done around STPs etc.”

Broader Points:

- “There are still issues relating to integration which remain unresolved.”
- “Needless duplication. Delays in discharge process.”
- “There should be a more joined up approach, including joint work with housing.”
- “We have seen no evidence that this will improve the funding situation.”
- “It does consume significant resource that might be better directed at the provider market.”
- “Talk the talk but cannot deliver. Need to speak the same language.”
- “It has to move on, there is a massive waste of resources with which real joined up thinking and partnership work could not only generate savings but improve the quality of services.”
- “All sectors can see how integration should work, but with shrinking budgets this fundamental shift does not seem likely to take place except very slowly.”

Question 6

There has been a deterioration in the overall quality of care, which is likely to continue.

NON-ISSUE	14%
LOW LEVEL	12%
MEDIUM LEVEL	22%
HIGH-LEVEL	32%
CRITICAL	20%

Comments by respondents

Implications for Providers:

- “There is a direct correlation between staff pay, the level of funding and the quality of care.”
- “We continue to deliver a high quality of care.”
- “There is now better reporting of quality issues and increased identification of inadequate quality care.”
- “We have struggled to ensure that all service users are observed at all times due to the nature of the building and increased complexity of the service users.”
- “Reputational damage is an issue, as despite committing all resources available sometimes... due to these resources not being enough, care quality falls short of what we expect.”
- “If anything, we have increased quality despite poor funding.”
- “Rushed, tired, stressed staff.”
- “This is central to the balance which providers like us try to maintain, between the properly increasing standards of care required, and diminishing budgets, or static hourly rates of care fees.”

Implications for Commissioners:

- “Mainly around care at-home due to recruitment and retention of staff and quality of registered managers.”
- “Decrease in quality has been most noticeable in the care-home sector, where there is a rise in homes becoming rated as requiring improvement or inadequate.”
- “Outcome based contracts in the Framework aim to ensure quality of care will be improved.”
- “Access to equipment has been removed; a very dubious decision as to why our residents are no longer entitled to free NHS equipment but people in Council - and other homes - are.”
- “Quality of care is high, but the quality of service user enablement is suffering due to cuts in one-to-one hours.”

Broader Points:

- “CQC inspectors do not take into consideration the complex needs of the customers who come to us. Local authority staff are far more approachable and supportive.”
- “The number of poor CQC inspections being publicised puts all providers regardless of performance in the spotlight and viewed poorly.”

Question 7

Councils are providing care and support to fewer people and condensing it to those with the highest needs.

NON-ISSUE	5%
LOW LEVEL	12%
MEDIUM LEVEL	38%
HIGH-LEVEL	36%
CRITICAL	9%

Comments by respondents

Implications for Providers:

- “This affects us in many ways; recruitment, training for staff to manage increased needs, relationships with health and social care commissioners.”
- “Increasing dependency levels of residents is impacting on staffing levels, which means we are incurring a higher wages bill which is an increased cost for providers.”
- “This puts a greater emphasis on the staff training and development to ensure that services are both safe and sustainable and that staff feel supported.”
- “The clear change in criteria of eligibility for services means we have had to consider our future business model for the future.”
- “There is increasing pressure on this service as responsibility seems to transfer to the voluntary sector, but all without investment in ensuring our sustainability.”

Implications for Commissioners:

- “Councils are providing statutory services to people in line with identified social care needs. Lower level needs are being supported through the signposting to, and further development of, a community and voluntary sector offer.”
- “The Council has a focus on community-connecting, using a new Community Book Directory to help people connect with communities.”
- “The Council is active in early intervention work wherever possible.”
- “We need to be smarter in utilising more informal services and having the intelligence to track whether that reduces or delays the need for formal care.”
- “People need to be supported through robust early intervention and prevention via access to informal support through the voluntary, community and faith sectors, all of which can offer a community focussed approach.”

Broader Points:

- **“Lower level contracts are going uncared for by the Local Authority.”**
- **“Focussing care on those with the highest needs is a false economy.”**
- **“We should be meeting identified eligible needs, not wants.”**
- **“The squeeze: FACS criteria applied more stringently, then sees a reduction in the time available to do these more complex tasks.”**
- **“This is negative for people who have a mild or moderate learning disability who become trapped in what is a competency trap.”**
- **“Social Care needs to be looked at holistically, in terms of prevention and all public money, rather than in a silo. A more holistic approach could prevent higher costs later.”**
- **“Care should not be rationed and the current treatment of social care, when compared to health, is a national scandal.”**

Question 8

Care provision is starting to be provided at the minimum level required for a person to get through the day.

NON-ISSUE	6%
LOW LEVEL	13%
MEDIUM LEVEL	34%
HIGH-LEVEL	31%
CRITICAL	16%

Comments by respondents

Implications for Providers:

- “There is a requirement that care tasks are conducted in a short a time as possible; this puts pressure on care staff.”
- “There is an impact on the morale of staff who would like to do more for their service users but haven’t enough time to do so.”
- “We concentrate on quality care and believe in going the extra mile.”
- “Impacts on our current and potential future service users as the complex nature of individuals with mental health needs is being overlooked.”
- “As funding is now only for their basic needs the individuals are becoming socially isolated.”
- “Leaves very little room for aspirational development e.g. person-centred planning/ practice.”
- “Increasing dependency levels of residents impacts on staffing ratios and occupancy levels.”
- “Just enough care’ raises moral and ethical issues as well as practical ones.”
- “We often do things that we are not receiving funding for as people are not receiving appropriate funding for their needs. This obviously costs the organisation and reduces our efficiencies.”
- “Service users are being placed at greater risk with an increased likelihood of a more rapid deterioration in health and loss of independence. This places greater pressure on care staff.”
- “When we request a review because a customer’s needs have changed, and an increase is required, it can take months to happen which is not” acceptable.”

Implications for Commissioners:

- “The principles of care and support should be to progress independent living. Many traditional services do not reflect this aspiration and are being replaced by more personalised service options that provide “just enough support” to ensure that services do not create dependency.”
- “The evidence does not really support this. For example, home care packages have remained very consistent at an average of 10 hours per week from 2016 to today.”
- “Some strong and effective work with providers and in-house services; aligned with smarter working practices.”

Broader Points:

- “Providing the minimal level of care is counter-productive and increases hospital admissions which increases overall state costs.”
- “Minimal support only serves to keep a person (at best) at the same place - institutionalising their view and preventing them from achieving any meaningful change in their life.”
- “Having care provided at the minimum level reduces the access to an individual’s community.”
- “This therefore reduces the quality of the outcomes they experience.”
- “The assessment and care planning process are like walking a tightrope created by financial pressures to reduce spend.”
- “This erodes the opportunities for people to increase choice, competence, individuality, and independence and their presence in the community.”
- “To even consider minimal care as the default option to those in need as a mature society with high taxation levels and a national insurance system is, again, a national scandal.”
- “Clients end up requiring more is often suggested but not necessarily true.”

Question 9

Reliance by care providers on private clients [paying higher fees] to subsidise local authority funded clients.

NON-ISSUE	20%
LOW LEVEL	18%
MEDIUM LEVEL	23%
HIGH-LEVEL	27%
CRITICAL	12%

Comments by respondents

Implications for Providers:

- “Our fees are charged at the same rates as those the councils for that area pay.”
- “We use the same hourly rate model across the board for private and local and local authority funded work.”
- “If the actual cost of care was reflected by the local authority in their fees, this would not be an issue.”
- “This is very rare.”
- “We do not differentiate. All our fees are the same regardless of who is paying them.”
- “Our overall viability is lessened due to subsidising our authority clients through our private clients.”
- “We can only continue to operate in the sector if we have a high level of private customers or third party top-ups due to low level of fees paid by local authorities which often does not represent the actual cost of care provision.”
- “We don’t charge more for private clients, but it is becoming an increasingly difficult decision for us to stick to.”
- “The difference is approximately £120 per week.”
- “Having private funders means that you work out an appropriate hourly rate for services being provided rather than trying to manage with a bench-mark rate.”

Implications for Commissioners:

- “There is evidence that third party top up fees are increasing in residential and nursing care.”
- “Feedback from providers who have closed homes is that they cannot solely rely on council funded placements.”
- “Anecdotally, there are some examples of cross-subsidy of local authority placements from other/private services. Not necessarily born out in financial modelling exercise.”
- “This is what happens with providers who take local authority funded people as well as private people.”
- “Some of our reablement services are run in an efficient manner with no current waiting lists for discharge. This is due to the services being appropriately funded and the Council allowing us to get on with the job with minimal interference.”
- “Providers who only take private clients have a very straightforward business model. Those who can’t pay can’t come in or must leave.”
- “We are currently turning away some private care packages because our resources and capacity are being pointed towards the needs of the local authorities we are in partnership with.”
- “Many local providers choose to work exclusively for self-funders and will not enter into a contract with the local authority. The funding squeeze has also exacerbated this problem, as an inability to inflate fees has encouraged providers to leave the contractual market or apply above-inflation increases to their self-funding residents.”

Broader Points:

- “This is discrimination and people will cancel.”
- “This is not ethical. All individuals should be treated the same. We have been forced into taking on more private customers to be able to survive in the industry.”

Question 10

There have been increases in delayed discharge from hospitals, and emergency admissions into hospital.

NON-ISSUE	8%
LOW LEVEL	23%
MEDIUM LEVEL	23%
HIGH-LEVEL	33%
CRITICAL	13%

Comments by respondents

Implications for Providers:

- “When people are waiting to be discharged to our services, and there is an ongoing argument about responsibility for payment between health and social care teams, it impacts on the availability of beds.”
- “We are under increasing pressure from social work teams to accept care packages, often at very short notice. Unsafe discharge is a pretty regular occurrence.”
- “We have had rooms waiting, but the local authority and some CCGs fail to get the paperwork and contracts done, which sometimes takes days to happen.”
- “Some of our reablement services are run in an efficient manner with no current waiting lists for discharge. This is due to the services being appropriately funded and the Council allowing us to get on with the job with minimal interference.”
- “We participate in the Care Home Innovation Programme which has resulted in a decrease in admissions to hospital.”
- “It is time consuming when expecting a new client from the hospital and the discharge is delayed. Recent experiences have been with no transport to get the person home.”
- “The issue for us is that the local authority doesn’t move fast enough on the discharge and delays the process.”

Implications for Commissioners:

- “In recent years, we have been involved in some proposed discharges from hospital that we believe would have resulted in the person needing to be readmitted very quickly. Thankfully, in these situations, we have been a clear partner with the local authority and health which has resulted in better outcomes for all.”
- “Due to some individuals needs, it can take some time to have everyone who is needed to be involved in Multi-Disciplinary Teams or discharge meetings.”
- “Delayed discharges are normally due to equipment provision, medication delays or late transport.”
- “Funding arrangements are awaiting authorisation.”
- “Our problem has not been delayed discharges, but inappropriate discharges.”
- “We have the capacity to take packages from hospitals, but don’t get enough referrals via the hospital.”
- “We do not have a significant issue with delayed discharges. There are weekly calls with health to monitor the situation, and provide updates on responses.”

Broader Points:

- **“Pressure from hospital trusts to discharge patients has put additional pressure on some social care provision such as domiciliary care. This often leads to inappropriate care packages being requested.”**
- **“The pressures on the NHS inevitably have an impact upon the people we support, and delayed and disorganised discharge from hospital is just one example.”**
- **“Typical public-sector problem (i.e. a lack of coordination and drive to address it).”**
- **“When you treat health funding as infinite and social care funding as disposable then it is an avoidable, yet seemingly clear, consequence.”**
- **“A concerted effort is needed to maintain and improve progress, whole system change is required.”**

Question 11

Unpaid carers are providing more hours of higher level care as councils have reduced provision.

NON-ISSUE	24%
LOW LEVEL	22%
MEDIUM LEVEL	28%
HIGH-LEVEL	22%
CRITICAL	4%

Comments by respondents

Implications for Providers:

- “The more unpaid carers are involved in providing care, the less work home-care providers pick up.”
- “We welcome relatives to come in and assist with meals and care as this helps the staff out.”
- “We are aware that there has been an increase in family members having to take on increased responsibility to support their relatives but not significantly with higher levels of care tasks.”

Implications for Commissioners:

- “There is no evidence this is because of reduced social care provision from councils. The council is increasing the support provided to carers to ensure they can maintain their caring roles and have a good quality of life.”
- “There needs to be more flexible funding for short breaks and earlier intervention.”

Broader Points:

- “If this is done in a positive and supportive way it is of great benefit all round.”
- “This can have an impact on the persons developing their independence from the wider family as in the usual norm in society - children do leave home as they become young adults. Also, the pressures on the health and welfare of family carers must not be underestimated.”

Question 12

The Select Committee considered that Councils struggle to fulfil their statutory duties to identify, assess and meet carers' needs for support.

NON-ISSUE	13%
LOW LEVEL	15%
MEDIUM LEVEL	43%
HIGH-LEVEL	21%
CRITICAL	8%

Comments by respondents

Implications for Providers:

- "This is an issue that families have raised with us."
- "Personal budgets are a help with this as planned short-stay over the year can be arranged with our company."
- "We are increasingly having to advise informal carers of their right to an independent assessment of their own needs."

Implications for Commissioners:

- "Most fail, and what is produced is poor at best."
- "Since the introduction of the Care Act, the number of carers who are assessed and supported has increased. In addition, several new services are being designed to support carers and the carers budget has increased to reflect an increase in demand."
- "Carers are sometimes forgotten if they carry on doing what they do."
- "The issue is the timeliness of the execution of the local authority's obligations."

Broader Points:

- "We work with many local authorities and the majority do not meet or just meet their obligations."
- "Councils appear to be nationally lacking the resources to meet their statutory obligations."
- "Carers feel alone and left to get on with things without little or any support."

Section 3: Workshops

The Engagement Workshops took place during July 2017. They were held in four sub-regions in pairs, with one for Commissioners and one for Providers. The sub-regions were:

- **LIVERPOOL CITY REGION**
- **WARRINGTON & CHESHIRE**
- **LANCASHIRE & CUMBRIA**
- **GREATER MANCHESTER**



The format allowed for each of the issues from the survey to be discussed in terms of what currently works well, and how it could be improved. Trying to steer a debate about social care into something positive is not easy, but there was plenty of positive thought about how things could move forward.

Additionally, seven key stakeholders - including representatives from the NHS, Skills for Care and local authority regional professional groups - were interviewed about the issues. The results of these interviews are included in the summaries of the workshops where appropriate.

In this section, we will summarise the outcomes from the discussion about the issues. We present the issues in the order of priority from the survey, so that the most pressing issues come first. In the next section, Innovation: Moving On, we suggest how these ideas could be taken further.

1. Provider Failure

“In the last two years, we had home care companies pulling out of contracts and not taking on new cases. The result was that we did not have enough capacity. We increased rate via an hourly uplift. It seemed to relieve the pressure and allow the market to keep stability.”

What’s good?

- Failing providers can be an inevitable function of the market, which is not necessarily a bad thing.
- With full provider engagement, commissioners can help them sort out their costs.
- Providers need to invest in their services – some do, some don’t.
- Some councils pay the whole fee, then collect the top-up from service users, which is good for providers. Others do not which passes the risk to providers.
- Provider forums can be a useful way of sharing good and prudent practice.
- Creative funding streams allow providers to rely solely on local authorities].
- NHS England provides guidance on dealing with provider failure.
- An understanding approach can be flexible to circumstance (e.g. the 2015 Cumbria floods).

But ...

- There is still a wide variety of providers in terms of size, ownership, governance, business models, values, clientele, history. A very mixed market.
- Affordability seems to trump quality.
- The HMRC sleep-in ruling and National Living Wage have a huge impact on provider viability.
- There have been delays in councils paying their new rates (ie. rates from April are not paid until September).

Future Direction:

- The sharing of market intelligence by commissioners from different local authorities and from other public agencies would help to avoid provider-failure shocks in the future. If commissioners were to rely on each other’s quality inspections the costs of monitoring could decrease for commissioners, while provider compliance costs could also be reduced.
- New models of funding providers based on open book accounting, including; block payments, incentivised payments, payments linked to outcomes, annualised payments.
- When a provider is failing, could the local authority step in to support that provider like the central government does for local authorities and health trusts?
- Early dialogue between commissioners and providers, before problems are acute helps.
- At time of placement, it is good to define likely future variables; for example, a client might be expected to need more help being lifted as they become older etc.
- When there is a small number of providers in an area it is better for providers. This creates more stability for providers (although potentially a higher risk for commissioners).

Commentary:

- This was an issue that really divided providers and commissioners. Many providers felt unsupported in a tough environment by commissioners. Many commissioners felt providers were not adapting to that tough environment despite offers of help.

2. Fee Setting

“We need a sustainable market, so fee-setting must be realistic.”

What’s good?

- Tell the story well and providers will come to you.
- Quality of relationships is crucial.
- Providers like to have access to elected members and senior leads.
- Open Book accounting: offered but usually declined.
- GM set of principles and agreed methodology.
- Review rate on a planned basis, review cases on a planned basis.
- We need to set principles and fees together.
- Work by Ernst & Young on care home accounts and % age capital returns.
- Work by CIPFA on ‘Getting the Price Right for Sustainable Care & Support’.
- Assistive technology solutions to overly expensive sleep-in situations must be developed.

But ...

- “I sent a list of clients we thought could have reduced care packages – never heard back.”
- Councils are not agile in responding to the changing needs of clients.
- Full costs are not taken on board by councils.
- Ending zero hours contracts has a cost.
- Take minimum wage and pensions into account.

Future Direction:

- Agree on a model of how to meet costs.
- Incentivised payments (linked to achievement by providers of outcome goals for clients).
- Mediated approach – but by whom?
- Pay accurately as there are high transaction costs for providers when overdue payments need to be chased.
- Get a Director / AD to meet with providers. It helps.
- Invite providers to come in for Open Book discussions if they need them.
- Set a standard rate for all providers.
- Let providers innovate and be flexible across budgets. The outcome is not time and task based.

Commentary:

- Local authorities struggle to negotiate the annual political process of budget setting so that providers know the rates in advance of the start of the financial year. If this could be achieved then providers would benefit, transaction costs for all parties would diminish, and trust and confidence would grow.
- This would help create conditions for collaboration, notably in parts of the region where the workshops showed a surprisingly high level of antagonism between providers and commissioners.
- The tools for the job are being assembled. CIPFA and others are providing resources that should make it easier to set agreed, fair and transparent rates quicker. The development of flexible outcome-based contracts with incentives for achievement should be the next step.

3. Workforce

Why would people be care workers when they can get paid more in Aldi?

What's good?

- Warrington social care academy, which is now onto its second cohort.
- Provider-led recruitment fairs.
- Apprentice schemes.
- Zero Hours is not always bad (e.g. it gives some staff the flexibility they wish for).
- Local nurse training to include placement of nurses in some care homes
- Leadership course with Edge Hill College to develop care leaders.
- Skills for Care have several recruitment, workforce development and leadership initiatives in the region; including a New Directors Programme and a Graduate Programme.

But ...

- An ageing workforce presents difficulties in terms of abilities, retirement and replacement.
- Brexit – implications are unknown but could be problematic.
- Other employers, for example supermarkets, pay more for less responsible jobs.
- Negative press towards care workers reinforces an image problem.
- The move to home care from home help has led to a less balanced job which may be less attractive to workers.
- Providers or individual workers have to pay for training themselves.
- Recruitment in the health sector is above the NLW leading to problems for Providers.
- NLW leads to a squeeze on differentials.
- No recognition of these workforce pressures on Providers in fee setting from Councils.
- There needs to be strategic direction across the region
- Low finishing rate for Care Certificate in the region

Future Direction:

- Use Better Care Fund for training; if all local authorities chipped in then a substantial budget could be developed to tackle the training issue on a regional basis.
- Recruitment Hubs, for example Warrington, brings together local employers, colleges, and the job centre plus to get the right messages out about who they want to work with.
- Sector based work academy route.
- iCare Ambassadors who talk about the work.
- Develop apprentice schemes
- Value based recruitment; as recruits are more likely to stay in the job.
- Trusted provider idea where providers are funded to provide training.
- Integrated health and social care, it must be advertised/promoted as a joint system for home care. Bring it together into one package.
- How do we make the job more attractive?
- Any integration of Health and Social Services could be a vehicle for a more innovative approach to workforce issues.
- Could providers pool together to deliver training to each other? Could be an asset-based approach for providers.
- Improve career pathways / link to colleges. Encourage unpaid carers to become paid carers.
- Try to understand our employment market. Bring retirees 60+ into the employment market?
- Value-based recruitment
- Need career pathways for staff within a care organisation (even small providers).
- Need a career route other than the nursing route.

- Can we cut down on travel between jobs for staff?
- Integrated career framework across social care, with an entry level focus.
- Improve status by integrating health with social care recruitment.
- Accountable care partnership - get whole system approach to this. Create pathways to nursing and cross fertilisation of recruitment.
- There is a need for a national approach.
- Providers could do training together – asset-based approach would be useful. Collaborative approach needed.
- What is a professional carer? This needs to be defined. Early discussions have been held. All the training is in place, quality assurance systems are there, it just needs branding and being pulled together under a banner with governance to ensure standards remain high.

Commentary:

This issue has both some of the biggest challenges, and the largest range of practical solutions. Skills for Care in the region has a raft of initiatives and ideas for employers to tap into, which were published nationally in May 2017 in the 'Recruitment and Retention in Adult Social Care: Secrets of Success' report. This report documents its learning from employers about what works and covers the key areas of how to:

- Attract more people; including having attractive reward packages and developing a reputation as a good employer.
- Take on the right people; including value-based recruitment approaches and weighting life experience and a willingness to learning highly during recruitment.
- Develop talent and skills; including a wide variety of formal and informal approaches that should be enabled at all stages of a person's career.
- Retain people; including all the above. Also offer flexible work patterns, accommodate staff responsibilities outside work, and seek out and act on staff feedback.
- Take the local recruitment context; such as what competing employers are doing, into account when planning to improve recruitment and retention

A look through the future directions suggested in the section above shows how many ideas there are amongst stakeholders. Local strategies, however, could usefully be augmented by a more strategic regional approach, and an associated pooling of resources towards this response.

4. Market Shaping

“If I had been wanting to open a factory that employed 40 people I would have been met with open arms by the Council. But I was wanting to open a care facility, and the response was far from enthusiastic”

What's good?

- Market shapers, finance leads, performance leads and HR leads meet across the region.
- Gain/share agreements can be important in improving care, saving costs, and building trust.
- Individual Service Funds – incentives for care and support – risk gain share for reduced levels of support.
- Most commissioners using dynamic purchase systems which can encourage new entrants.
- Commissioners giving providers information about commissioning needs and intentions
- Needs Mapping events can help providers understand needs and create a dynamic market.
- Commissioners are moving towards soft market testing to get collaborators for a co- production approach.
- We need to be bold and innovative with innovative approaches to home care.
- Different models of delivery are being explored, Liverpool care homes to be leased to care providers.

But ...

- Communication with providers needs improving.
- Mini-competitions within Frameworks are harmful for provider relationships.
- “We set up a 6-bed unit – plug pulled after 6 months”
- Contracts that demand you take all cases are not good.
- Consultation must be meaningful.
- Need honest communication.
- Hard to find someone in the Council to talk to about proposed new initiatives.
- Hard for Health and Local Authority to jointly commission from different value bases.
- “You always come to us with a fait-accompli” we want to move to soft market testing.
- Commissioners come to us saying ‘we need 3 four bed supported living units for people with learning disabilities’. We would much rather they came earlier in the process and asked, ‘how can you help us meet the needs of 12 people with learning disabilities in the community?’

Future Direction:

- Technology is important. Providers must try new tech, assistive tech, telecare, tele-health. If providers have a new idea they need to feel able to approach commissioners with it.
- Sub-regional collaboration on Learning Disability may be appropriate and achievable.
- Share demographics and understanding of needs etc. with providers.
- Go to market stating what needs are to be met (not how to meet them).
- Commissioners need to court big providers – get them in your area.
- Providers can work together to co-produce.
- A Market Position Statement and an Investment Prospectus would be welcomed.
- Commissioning must be seen as more than just contracting.
- Local authority needs to say what numbers are on an annual basis.
- The Good Cities Economy approach advocated by the Centre for Local Economic Strategies [CLES] provides a model for a more economic approach to the care market, seeing the care market as a key part of the local economy rather than just a service provided. The approach presents an opportunity for synergy by tackling economic and social wellbeing objectives simultaneously.

Commentary:

- This is an area with much potential. The new approaches to home care in Trafford, Cumbria and elsewhere, the move towards co-production, soft market testing and a more economic model approach to the social care market are all positive.

5. Social Care & Health Integration

“We went to interview a complainant about the care he was receiving. He produced a list of twenty people he had been given to contact”

What's good?

- The Greater Manchester informal pooled budget (due by April 2018) will pool adult health, public health and adult care budgets. If it is a success, it would be an obvious benchmark to follow.
- Many examples of good practice across the region.
- The “Buurtzorg” model of home care is influencing working practices in teams in Greater Manchester.
- Trafford home care / district nurse pilot.
- Ground floor is integrated; at a strategic level, not so much.
- It has begun!

- This is ongoing and will take time, but there is no need to rush. This needs to be done carefully. Pace is important.
- Almost impossible.
- Growing accountable care partnership – gets tricky when it comes to pooled budgets etc.
- Addressed in Wigan by Service Delivery Footprint system. It works.

But ...

- IT incompatibility is a big problem. Pilots with the NHS in Rochdale, Liverpool and Manchester could point the way forward.
- Pooled budgets will still have to address the difficulty of health service being free unlike social care services.
- The hourly rate paid to Providers by the NHS is less than the local authority rate; so we can't take health clients.
- Social care is looked down on by health staff.
- Assessment and re-assessment by many assessors is majorly frustrating for clients.
- Formalising (via section75) can put strain on the informal goodwill etc.
- National drivers can undermine local joint work; for example, Trusts must increase income, but this can only come from the local authority or the CCG.
- Joint funding leads to more uncertainty for providers.
- There can be a lack of trust between social services and health services.
- Culture: value base differences between health and social services.
- There is a cycle whereby enthusiasm for a new health/social services initiative can drip away once reality dawns.

Future Direction:

- Look at other countries.
- Develop joint pathways.

Commentary:

- Take away the world weariness that can cloak much discussion of this issue. There is evidence of very significant progress in parts of the region already and of real opportunities for progress in other parts.
- The Trafford home care pilot offers a glimpse of how to achieve both service improvement (a more coordinated service for users) and financial savings (rooting out duplication).
- The Greater Manchester pooled budget could be a model that could be adapted and used across the region.
- If some of the initiatives that are about to start, are successful then savings could be replicated across the region.

6. Quality Deterioration

“Is the issue quality deterioration or just that more publicity is now given to scrutiny and inspection reports?”

What’s good?

- Joint inspections are considered a good development by many providers.
- A strong relationship between Safeguarding and Quality Assurance staff is important.
- The CQC does highlight good practice as well as bad in the region. This focus on good practice is necessary.
- Good relationships between providers and commissioners / quality staff in local authorities are important in creating an environment in which quality concerns can be discussed positively.
- Councils are looking to implement quality improvement teams to target those providers that need improvement. Early warning dashboards are being developed.
- Some CCGs invite care home staff to appropriate training that is taking place.

But ...

- Is the issue quality deterioration or just that more publicity is now given to scrutiny and inspection reports?
- There is a danger of providers bidding for contracts that they cannot easily deliver (lack of due diligence).
- Providers have a feeling that commissioners are wanting more for less.
- Direct payments can lead to unregulated staff, which is a real and latent quality and possible safeguarding concern.
- Pay by the minute, where it exists, runs counter to quality.

Future Direction:

- There is a need for more local authority / NHS cross-agency collaboration, in terms of inspection content, inspection visits and paperwork.
- There is a need for local authorities to work closer with health and other agencies to develop sharing of intelligence (ie. concerns, positive messages, joint visits etc.).
- Commissioners and Providers both need to consider how inadequate quality can be managed towards improvement.
- All authorities who place clients in an area need to agree to act in unison.
- Commissioners need to aim for an agreed set of regional quality measures using online tools.
- Commissioners need to learn how to use CQC and other data to more effectively monitor quality.

Commentary:

- This issue was the first one to really bring out the differences between providers and commissioners. Providers felt that quality was an inevitable casualty of the driving down of costs that commissioners are keen to deliver.
- There was a widely shared view that better coordination of quality assurance staff with other inspection regimes, for example the CQC and local authorities, could improve the quality and efficiency of inspection and regulation. This would benefit commissioners, providers and, most importantly, the people who use the services as listed below:
- Improvements in how quality is assured and improved by providers and local authority staff are likely to improve care quality.
- Provider transaction costs connected with inspection and investigation of specific situations would likely decrease with more co-ordinated inspection regimes.
- These changes, however, are not likely to deliver bankable savings.

7. Highest Needs Priority

“Social Care needs to be looked at holistically in terms of prevention and all public money rather than in a silo. A more holistic approach could prevent higher costs later”

What’s good?

- Signposting of clients to community resources.
- Encouraging the use of assistive technology.
- Community connectors, staff who can facilitate people accessing community resources to meet their needs.
- Getting the Head of Planning to engage with the health and social care agenda, ensuring that it is included in the new local plan.
- A recognition that the social care world operates on an All / Some / Few model.
- Example: Warrington prevention hub (which is public-health led and has a holistic approach to low level need) includes mental health and people who are “worried well” with third sector, housing and social workers. Currently town centre based, it will go out to neighbourhoods through the GP cluster model, working with willing GPs in the first instance. Their evaluation will take place through referrals, what services are accessed and test out if referrals re-present themselves after a suitable period.
- All authorities who place clients in an area need to agree to act in unison.
- Commissioners need to aim for an agreed set of regional quality measures using online tools.
- Commissioners need to learn how to use CQC and other data to more effectively monitor quality.

But ...

- Having less low-level care cases changes the nature of the work and the shape of the workforce; care work becomes harder and more technical with less respite.
- 3rd sector and other community resources need support and investments which is hard to come by.
- Some initiatives which should help such a response have not always integrated into social care as well as they could (e.g. Safe & Well with the Fire Service).
- Cross-agency information sharing is problematic – as is using and accessing data.
- The idea that slack caused by less state provision can be picked up by the voluntary sector and the community is a myth.

Future Direction:

- If the effectiveness of prevention work could be measured, investment would be easier to argue for.
- A live-well portal with information and guidance, through which people can self-assess and fast track equipment on-line.
- Advice and information is crucial – but community capacity is small.
- Home Improvement Agency (3rd sector) could be part of a Prevention Hub
- “All, some, few” provides a useful way of looking at services. All the population can use some services (i.e. libraries), only some use other services (i.e. home care), and a few use very specialised services (i.e. specialised physio or nursing care).

Commentary:

There was a broad acceptance that this is the new reality. That the days of statutory services for those with lower needs were going or gone. The emphasis for the future would seem to focus on:

- Quantifying the benefits of preventative work that slows down the development of eligible needs.
- Improvement of information and sign-posting services so that people with low level support needs and their carers can access solutions directly.
- Fully informing people with support needs of assistive technology solutions.
- Adopting a multi-agency “consent based” approach that tackles information sharing issues.
- Cost effective preventative work may delay or stop people entering high-needs services. Until costs and benefits can be measured and costed, however, it is hard to justify investments in new preventative measures.
- Better information and sign posting will assist people to access self-directed support and to remain independent of statutory care and support services for longer.
- Using assistive technology more should result in less care being delivered by both unpaid carers and paid staff. Systems to measure the amount of assistive technology in use and any associated savings need to be developed before savings can be predicted.
- Multi agency information sharing (when consent has been given), where several agencies supporting the same person will enable support to be more co-ordinated so to avoid unnecessary duplication; will be more person centred and individualised.

8. Minimum Level of Care

“Long term this could result in a culture of smaller, cheaper care packages supporting independent living with reduced costs”

What's good?

- Not creating dependency, through over-provision, was seen as an important and positive outcome from this issue.
- 'Just enough' can really work.
- Assistive technology systems can benefit from initial council capital investment.
- iPads, Skype, Apps are the way forward, technology can lead to reductions in night staff.

But ...

- There are big differences between care groups; for example, over-provision for young people with learning disabilities can hamper independence and progression.
- Tools such as the Care Fund Calculator have led to a time and task approach that does not work for everyone.
- The quality of life for the user can suffer (for example, there is no time for a cup of tea with the care worker) and the work can therefore become more unrelenting for staff.
- With Supporting People projects closing we are about to see [anecdotally] a swell of needs shunted to the NHS.
- The ADASS budget survey showed a marked decrease in prevention budgets. There are no cashable returns, meaning it is very difficult to make a business case for prevention. We need to utilise Public Health expertise to help make the case for prevention services.

Future Direction:

- The quality of initial and continuing assessment of clients is key.
- Co-production and outcome-based service monitoring will help provision to become dynamic, responding to clients' assessed needs.
- The trusted assessor concept, being trialled by some authorities, can lead to a more dynamic assessment.
- The task is to meet eligible care needs with natural assets.

Commentary:

This issue can lead to unsatisfactory care situations with people unable to achieve independence. Whilst the discussion in the workshops recognise this, they also adopt a positive approach to dealing with this issue. Not all the resulting implications of the issue are negative. The emphasis for the future seems to need to focus on:

- Improving initial and on-going assessment of people with social care needs (including investigating the trusted assessor approach whereby providers are involved in assessment) to encourage independence not dependency.
- Developing an outcome-based approach to commissioning and also, crucially, to monitoring.
- Encouraging the development and use of assistive technology.
- Ensuring that Public Health input is as productive as possible with prevention work being effective and targeted.

Any benefits here are likely to result in:

- More care and support (for example via assistive technology) for people on top of the minimum level that they currently receive.
- More targeted care packages, with care geared to fostering independence rather than creating dependency.
- Long term could result in a culture of smaller, cheaper care packages supporting independent living with reduced costs.

9. Cross Subsidy

“We couldn’t survive without it” or “We would never do it”

What’s good?

- Cross subsidy allows us to boost the income to the home and keep staff on all day - getting rid of split shifts. This leads to a better standard of care, more staff satisfaction, and subsequently better staff retention.
- It does cost more to invoice private clients as opposed to local authority clients (post invoices etc.), so there will be an up-charge for that aspect of the care.
- It is easier to agree uplift (with benefits) to private clients than it is to try and get an up-lift from a local authority.
- Top ups can be used for the specific benefit of the private client; this is different to paying more for the same level of care.
- Private user top-ups are common even in nursing homes (where the care is free).

But ...

- We don’t like doing it, but we have to.

Future Direction:

- Need transparency around the fees that providers charge.
- Need a minimum standard.
- The Competition and Markets Authority market study into care homes for the elderly will provide a pointer to a likely future response to this issue.

Commentary:

- Commissioners were not worried about this issue as the public purse benefits from the cross subsidy from self-funders. The losers are self-funded customers. It is a far from an equitable response to the current social care market, however, and is unlikely to be allowed to continue indefinitely by central government.
- A practical way forward is where a “minimum” standard of care is specified, costed and agreed. All customers would:
 - Pay the same rate for this regardless of how they are funded.
 - Have the option to pay for add-ons over and above the agreed minimum service.
 - Private funded customers might be expected to choose more of these, but public funded customers would also have the option to pay top up fees.

10. Hospital Discharge and Emergency Admissions

“In the Wirral, the local authority and CCG working closely with the third sector commissioned interim care in people’s own homes [Home Instead] which worked well, and helped take pressure off Hospital admissions and discharge.”

What’s good?

- Care Home Improvement Plans and results from the Enhanced Health in Care Homes pilots should result in less emergency admissions for care home residents.
- Providers appreciate retainer fees when residents are admitted to hospitals; these vary across the region.
- Some initiatives, for example tele-meds, appear to work well (but can then fizzle out).
- Technological help at home is good but needs to be easier to access.
- Systems can work well, until problems over which agency is going to pay derail them.

But ...

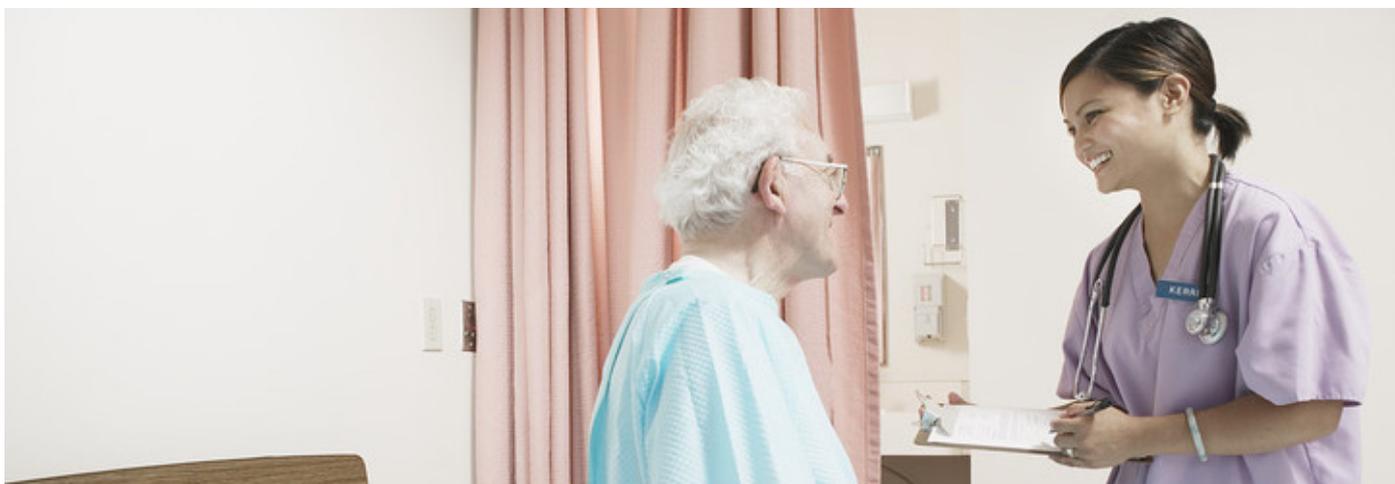
- Family choice is seen as a cause of discharge delays “is a big problem”.
- A risk of adverse nature in homes can lead to a “better go to A&E to be safe” culture.
- Out of hours approaches to primary care often leads to “send them in to A&E” responses.
- Once hospitals are on red alert all agreements about discharge times etc get overruled.
- Basic difficulties in getting equipment to people’s homes is slowing discharge down.
- Performance variation between areas is so wide that there must be cultural issues.
- Leadership is failing.
- Sustainability is the key. Successful schemes do not necessarily get replicated, and they can fade away as they are often dependent on personalities.

Future Direction:

- Need more step-down services to enable people to leave hospital before they can go home.
- Care records should be able to be shared easily between social care and health staff
- There is a need to find time to look at system-wide solutions.

Commentary:

- For an issue that has such a high national profile this seemed a surprisingly muted point for discussion. This was put down to “initiative fatigue” by one participant. That said there are obvious commissioning/market shaping issues.
- Access to appropriate community step down and step up services related to DTOC.
- Access to appropriate health care for residents and service users to avoid unnecessary emergency admissions to hospital.
- Many discharge delays are linked to system-friction which, although causing problems across the social care system, are often quite localised around the interface between internal hospital departments or the interface between the hospital and the community; the high cost to local health and social care systems has been well documented nationally.



11. Minimum Level of Care

“At the moment, an alarm system goes to the family if activated. If we put in a ‘go to warden’ option, we reduce the family role and create a dependency on the paid warden.”

What’s good?

- There is support for carers.
- Some Councils creating one-stop shops for carers.
- Information, advice and guidance are crucial.
- Personal budgets can be used in innovative ways (phone apps etc.) to increase carer independence (for example, carers being able to keep working in paid employment).
- Not sure it is a problem, as unpaid carers, are good for users.
- Needs to link into Sustainability Transformation Plans.

But ...

- People doing the care, whether unpaid carers, or direct payment personal assistants need care training.
- There has been a change in behaviour as there is often a different work/life balance today resulting in families being less keen to take on caring roles.

Future Direction:

- Evaluate existing carers services in the region to learn and document what works best.
- Augment learning from what works within the region with research into what works well elsewhere in the UK and around the world.
- Use the above learning to strengthen existing services to support carers and better enable peer support across the region.
- Ensure Information, advice and guidance is up to date and easy to access
- Provide unpaid carers with access to a portfolio of structured training to help them be effective carers and to be resilient. This would need to be seen in “an invest to save” context (it would of course come at a cost though).

Commentary:

- This issue is seen by many as a new reality. By supporting carers, particularly with information, councils can continue to have the burden of care shared between families and the authorities.

12. Carers' Needs

"It is simple; carers need information."

What's good?

- Once carers are identified then we have a referral pathway that leads to assessment of need.
- In house carer assessor teams.
- Carer centres.
- Carer pathways.
- Sitting services.

But ...

- Councils struggle to identify who the carers are.
- Short term funding for many carer services create cliff-edges: there is no taper. This can prove very problematic for the services and carers.
- Respite services for carers seem to have disappeared (planned and continued respite).
- No preventative budgets mean it is difficult to develop carer support services.
- Carers have to pay for respite in a complicated way. This puts them off using it.

Future Direction:

- Need to identify carers so information about support can be better targeted
- Sharing is the best practice.

Commentary:

- Local authorities seem to be meeting their Care Act responsibilities to various degrees. Picking up on the good practice in the region (ie. Carer Centres, a Carers pathway etc.) is likely to be the best way of improving services to carers.

Section 4:

Secondary Research

Secondary research was used wherever possible to triangulate, support and add to the ideas and views that emerged from the engagement activity; the survey, the interviews, and the workshops.

In this section, we present a summary of our findings under the issue headings ordered, as in section 3 (i.e. by the priority ranking allocated after the survey).

1. Provider Failure

There is evidence to confirm the stakeholder perception that provider failure and market sustainability is a significant risk across the North West. For example: Nationally, the ADASS Budget Survey 2017 found that 69% of Directors have been affected by the failure of a care provider in the last 6 months.

- The 'Local ADASS Director Survey' reveals that the risk of provider failure/withdrawal seems real, as fee rates in the North West are below the rates that providers say are sustainable and ASC's ability to fund increased rates is limited as real term ASC budgets are reducing.
- The "As Is" market analysis shows that all markets overly rely on a few large providers. Therefore, the market is vulnerable to the failure of a large provider. For example, table 2 below shows that biggest providers account for between 25% and 44% of expenditure in each of the four markets analysed:

Table 2: Market Analysed	5 biggest brands	5 biggest non-brands
OP Res/Nursing	21%	4%
OP Dom Care	18%	12%
LD Res/Nursing	20%	10%
LD Community	31%	13%

2. Fee Setting

There is evidence to confirm the stakeholder perception that not being able to afford rising costs because of fee and demand increases is a high-risk across the North West. For example:

Budgets are being overspent

Nationally the ADASS Budget Survey 2017 found a reported overspend of £366 million against 2016/17 budgets and the confidence that Directors have in being able to deliver savings is falling. In 2015 45% of Directors were fully confident that planned savings would be met, but in 2016 that percentage had fallen to 31%. In 2017 the figure remains at 31% despite the additional funding and further reductions to 8% for 2018/19. It is fair to say that Adult Social Care is finding it “increasingly hard to make ends meet”.

NW Directors have identified Financial Stability as a top priority

Locally, 16 out of 19 (84%) North West local authorities gave “responding to demand / financial pressures” as one of their top three priorities for 2016/17 in the Governance section of the local performance dashboard.

The overall financial context where demand growth is exceeding the growth in funding levels means it will be hard for ASC to afford the fee increases that providers are demanding. This in turn makes it harder for ASC to address:

- Market shaping challenges, as affordable fee levels may not be attractive to potential new market entrants.
- Workforce challenges as affordable fee levels may not fund wages at a level that attracts and retains skilled staff.

On the positive side, an apparent increase in BCF funding at most local authorities mean that provided information should help fund activities that will to:

- Effectively address rising DTOC levels.
- Enable greater integration between NHS/ASC.

Providers say fees are too low

“Paying for it – The Human Cost of Cut Price Care”, a March 2017 report by the LGiU calculated an economically viable cost per hour of care is between £15.91 (calculated by Mears) and £16.70 (calculated by the United Kingdom Homecare Association).

Data shows average rates paid in the North West are below what the level providers say they need

The 2017 ADASS Budget Survey shows that the average rate per hour in England was £15.39, so it seems likely that fee increases of between 50p and £1.30 per hour may be needed.

Hourly Rates in the NW are amongst the lowest in England

The ‘Care Markets and Quality Report’ for the ADASS Executive Council on 7 September 2017 analysed and compared the hourly home care rates paid by Region. This showed the North West paid the 3rd lowest hourly rate *out of nine Regions) as shown in the table 3 on page 44:

Table 3
Comparison of Hourly Rates Paid
for Home Care by Region

Region	Average Home Care Hourly Rate
NORTH EAST	£13.29
WEST MIDLANDS	£13.77
NORTH WEST	£13.81
YORKSHIRE AND HUMBERSIDE	£13.93
LONDON	£14.97
EAST MIDLANDS	£15.15
EAST OF ENGLAND	£15.87
SOUTH EAST	£16.04
SOUTH WEST	£17.72
ENGLAND AVERAGE	£14.95

Few local authorities pay the minimum hourly rate required by Providers

In August 2017, UKHCA published their 4th edition of “A Minimum Price for Homecare”. It updated their recommended benchmark hourly rate to £17.19. When the budget survey data is compared with the new figure, only 14% of councils (mostly councils in the South East, South West, with a very small number from London, West Midlands and East regions) are paying above the new benchmark rate.

Care Providers increasingly less willing to provide under current terms

Care providers are increasingly less willing to provide care under current commissioning arrangements at current fee levels. The Local Government Association estimates that the sector needs £1.3 billion immediately to stabilise the Adult Social Care provider market [ASC Funding: State of the Nation Report. LGA, Nov 2016].

3. The Workforce

The 2015/2016 National Minimum Data Set for Social Care for the North West

Conducted by Skills for Care the 2015/16 NMDS confirms the perception that workforce skills, recruitment and retention are a real immediate and future area of challenge. It shows:

- The average age of workers was 43 years old, and 20% of workers were over 55. There is a need for more workers to be recruited in line with local demography as core workers retire. This will be a recruitment challenge with an associated cost.
- 83% of senior care workers and 51% of care workers were qualified at level 2 or above; so, there will also be a need to invest in training for the new recruits.
- 44% of new starters leave within 12 months and people under 20 years of age are even more likely to leave quickly. Retaining new recruits will also be an issue, although research has shown that higher wages do help to improve retention.
- The majority (91%) of the Adult Social Care workforce were British, 3% had a European Union nationality and 5% a non-European Union nationality. However, 21% of nurses, however, are not British, so there are opportunities to address staff shortages from overseas, but the impact of Brexit may stymie this opportunity and hamper certain key roles such as nurses.
- There was an average of 6.1 sickness days per worker = 1.1 million days lost per annum. There are opportunities to reduce this number of days lost as rates vary a lot across job-types. For example, Social Workers average 14.1 days, and Occupational Therapists 11.1 days, whereas Registered Nurses average just 2.5 days.
- Domiciliary care is particularly challenging as well as a shortage of nurses.

4. Market Shaping

2015/2016 Performance Dashboard

Several indicators highlight challenges that show there is a need to further develop the local care and support market. For example, the North West has:

- A high rate of new permanent admissions into residential and nursing homes (712 per 100,000 Population) as against an England average of 628 per 100,000 population; this is 13.4% higher.
- Relatively few learning disability customers in paid employment (4.1% versus an England average of 5.8%).
- A comparatively low rate of service users receiving direct payments (23.5% versus an England average of 28.1%).

Market shaping was identified as one of the top 3 priorities for 2016/2017

- 8 out of 19 authorities in the North West that completed the Governance section of the 2015/2016 local performance dashboard identified market shaping as one of their top 3 priorities.

5. Health & Social Care Integration

This was a relatively low priority compared to its national profile. The political interest and scrutiny of the Better Care Fund, Sustainability and Transformation Partnerships, and Delayed Transfers of Care. There is little secondary evidence to validate this perception, but we do know:

- All local authorities in the region are active in a Sustainability and Transformation Plan, and all local authorities submitted their Better Care Fund plans last year and are expected to do so again in September 2017. So, it appears that top-down government requirements are being followed.
- Only 2 out of 19 (11%) North West local authorities gave “Improving Health and Social Care Integration” as one of their top 3 priorities for 2016/17 in the governance section of the local performance dashboard, and only one authority had “Improving DTOC rates” as a top 3 priority for 2016/17. Improving Adult Social Care and NHS Integration is not, therefore, a formally stated top 3 priority in the region. Bottom-up locally led initiatives may be less likely to have emerged and to be implemented. If this is the case opportunities may well be being missed. There is evidence, however, that top-down integration and large-scale projects - such as in Greater Manchester and the integrated Care Organisation in Salford - are being implemented when required.
- Improvements on a local scale are inevitably dependent on locality. Several good examples were noted at workshops such as the piloting of the Buurtzoig model of home care and the Trafford home care / district nurse pilot. Successful bottom-up initiatives, like these examples, that make a difference need to be identified, publicised, tailored and then trialled more widely across the region.

6. Care Quality Deterioration

There is evidence to confirm the stakeholder perception that quality of care in the local market is under pressure. For example:

Directors believe they are facing challenges

Nationally the ADASS Budget Survey 2017 found that 74% of Directors believe that providers in their area are facing quality challenges.

Locally, 74% of North West Local Authorities that returned data on their priorities gave “guarding against care market sustainability/provider failure” as one of their top three priorities for 2016/17 in the Governance section of the local performance dashboard.

Performance data indicates quality in the NW is below average for England

Several 2015/16 performance indicators confirm the perception that quality is a challenge, showing that the North West has:

- An above average number of complaints referred to the Local Government Ombudsman per 100,000 Population (4.8% compared to an England Average of 4.5%).

- A higher percentage (35%) of care homes assessed by the CQC as inadequate or requiring improvement compared to an England average of 29%.
- A higher percentage (41%) of care home beds assessed by the CQC as inadequate or requiring improvement compared to an England average of 36%.
- A higher percentage (24%) of other Social Care Providers rated by the CQC as inadequate or requiring improvement compared to an England average of 21%.

A regional survey of Quality Assurance approaches by North West ADASS has shown the wide variation in resources deployed into this activity.

The “Care Markets and Quality” report for ADASS Executive Council on 7 September 2017 analysed CQC quality ratings as at July 2017. This showed that in the North West the percentage of services (Nursing, residential and Domiciliary) where quality was Rated “good” or “outstanding” was less than average and in all three categories the North West was in the bottom three out of nine regions. See table 4 below.

Table 4
Regional Quality - % of Services Rated Good or Outstanding
by CQC July 2017

NURSING HOMES			RESIDENTIAL CARE HOMES			DOMICILIARY AGENCIES		
Rank	Region	%	Rank	Region	%	Rank	Region	%
1st	East of England	74	1st	West Midlands	86	1st	West Midlands	88
2nd	South East	73.5	2nd	London	85	2nd	South West	88
3rd	North East	73	3rd	North East	84	3rd	East of England	87
4th	South West	71	4th	East Midlands	84	4th	South East	84
5th	East Midlands	70	5th	East of England	83	5th	East Midlands	84
6th	London	69	6th	South West	83	6th	North East	81
7th	West Midlands	67.5	7th	South East	80	7th	North West	80
8th	North West	62	8th	Yorks & Humber	78	8th	Yorks & Humber	80
9th	Yorks & Humber	61	9th	North West	76	9th	London	77

7. Highest Needs Priority

There is evidence that services are increasingly being rationed in the North West.

Local ADASS Director Survey

- The prioritisation of people with high needs at the expense of people with lower needs is likely. This is evident from:
- Reductions in expenditure on prevention across the North West from 10% of net budget in 2016/17 to 9.5% in 2017/18.
- 35% of saving in 2017/18 in MTFP's being described as from service reductions

Kings Fund research (Home Truths - Social Care for Older People - March 2017)

This found there has been:

- A large (26%) reduction in the numbers of older people receiving local authority-funded social care – from more than 1.1 million in 2009 to 853,600 in 2013/14. It also concluded this reducing trend is likely to have continued from 2014/15 onwards, but changes to data collection means there is no longer a comparable figure.
- A smaller reduction in the number of people aged between 18 and 64 years getting help.

ADASS Budget Survey 2017

Nationally the survey found that reduced budgets are making it harder for councils to manage the tension between spending on statutory duties, prevention and early intervention. Spending on prevention was just 6.3% of budgets for 2017/18 compared to 7.1% in 2016/17 and 7.2% in 2015/16.

8. Care Quality Deterioration

Local ADASS Director Survey

The risks that service quality will reduce or that people will only receive minimum levels of support seem real; as each is a possible consequence of 35% of planned savings in the North West Region (from service reductions), while a further 59% of savings are planned to be from efficiency and "other" savings.

9. Highest Needs Priority

Kings Fund research

Recent Kings Fund research (Home Truths, Social Care for Older People - March 2017) confirmed that the perception of stakeholders in the North West is accurate. It found that Central Government grant reductions to Local Authorities have been passed on to care providers in the form of reduced fees, or at best, below inflation increases for the past 6 years. Consequently:

- Many social care providers are surviving by relying increasingly on self-funders.
- Providers that are substantially dependent on Local Authority contracts are in financial difficulty.

Local ADASS Director Survey

It will be very difficult to address the cross-subsidisation of care costs by self-funders as forecast growth exceeds increases in funding levels. Consequently, it is hard to see where Adult Social Care would get the funds to pay for the costs they would incur.

Competition and Markets Authority (CMA) Report

The interim report from the CMA in June 2017 highlighted several concerns about the social care home market. It aims to bring forward recommendations that will protect residents and their families, which will be expanded over the next half of the market study.

The recommendations made include examining how:

- People can be actively supported in making choices.
- Complaints and redress systems can be significantly improved to help people feel more comfortable reporting concerns.
- Residents and their families can best be protected, and how to encourage fair treatment by care homes can be encouraged.
- Local authorities can be encouraged to share best practice in procuring care home services and planning and developing provision in their areas.
- Investment for the future can be encouraged.

10. Hospital Discharge

DTOC (Delayed Transfer of Care) was in line with the England average in 2015/2016, but 2016/2017 data indicates, like all of England, that DTOC rates have continued to rise since April 2016. On a positive note, the rise in the rate in the North West is below the average increase for all of England (according to the most recent monitoring report on the local performance dashboard).

Local performance Dashboard

Data reported in the local performance dashboard shows DTOC levels in the NW are similar to levels in England as a whole. It also confirms the perception that DTOC is rising.

Table 5
Local Delayed Transfer of Care data for 2015/16

MEASURE	NW DATA	NW TREND	ENGLAND AVERAGE	BEST IN NW
% older people at home 91 days after discharge	82%	Improving	83%	94% St Helens
DTOC per 100,000 of population	12.2	Declining	12.1	2.7 Wirral
DTOC attributed to ASC per 100,000 of population	4.7	Declining	4.7	0.8 Salford

Local DTOC has continued to gradually increase in 2016/17 although the most recent monitoring report commented that “DTOC continues to rise in the North West, but this is an issue nationally too. When comparing the last two months of Q4, however, the NW only saw a 0.5% rise. This was the lowest increase of all regions nationally, comparing favourably with a national increase of 7%”.

11./12. Reliance on unpaid Carers/ Carers Needs

It was surprising that the two nationally important issues that relate to carers were perceived as the lowest two priority areas by the North West commissioners and providers that we engaged with.

Two National Reports

The March 2017 reports Home Truths - Social Care for Older People by the Kings Fund and The State of Caring by Care UK both report how important and how stretched carers are at present:

- The Kings Fund reported that by seeking to protect the most vulnerable people and make financial ends meet, local authorities have drawn more in the last 6 years on the resources of families and communities to provide for unpaid care (and most expect to increasingly do this).
- Care UK found and reported on a growing anxiety around the level of support that will be available to carers against a backdrop of cuts to adult social care services. For example, 29% of carers are worried that practical support for them might be reduced in the future, 34% reported a change in the services they or the person they care for receives and, 39% have experienced a reduction in the amount of support offered by social services.

Local ADASS Director Survey

There is little in the Directors responses that directly affects carers support and carers assessments, but a likely consequence of reduced funding and higher demands is the rationing of support on people with higher needs. Support for carers and the people they care for is likely to be increasingly rationed as well.



Section 5:

Innovation Moving On

Innovative ideas and experiences from the survey and the workshops, together with information gathered from the stakeholder interviews and from secondary research, have been pulled together around the twelve issues to produce a menu of various innovative responses to current challenges. We hope that Directors across the region will be able to take this section and develop action plans appropriate to their own situation and circumstances.

High Priority/ Critical Issues

Engagement highlighted the first two issues as needing to be addressed as a priority.

It has also shown that there are deep divisions between commissioners and providers that emerge around particular issues. To progress in this area, a more constructive relationship will have to be forged and maintained between partners within the whole system for care and support.

1 FAILING PROVIDERS

Innovation Aim:

To support providers in a sustainable social care market.

The North West is confirmed to be at considerable risk of failing providers.

Views on the causes and merits of provider failure differ between providers and commissioners.

Actions:

- Use market intelligence across the region to keep abreast of market vulnerabilities.
- Investigate collaborative ways of developing the market with providers in a sustainable way.
- Commissioners to have support systems to offer providers, including Open Book accounting.

2 FEE SETTING

Innovation Aim:

To establish a fee setting methodology that allows for a sustainable market with outcome focussed placements.

Secondary research indicates that this is an area of considerable regional risk.

Antagonism around fee levels is high in some areas.

Actions:

- Develop rate setting methodology from national best practice research and in close consultation with providers.
- Ensure outcome-based placements become the norm.
- Establish provider forums to explain the process and consult on changes to it.
- Reduce transaction costs (for payer and payee) associated with fee payment.

High Priority Issues

The next four issues were recognised as important across the board by survey respondents, but the workshops and secondary research indicated that issues 3 (workforce) and 4 (market shaping) should also be rated as of critical importance.

There was a far greater level of agreement between stakeholders over these 4 issues and about the best ways forward [although there were still considerable differences over the extent to which quality was deteriorating and if it was the causes]. Taking positive steps forward over this more fertile ground could pave the way for constructive dialogue over the more contentious issues of “fee setting” and “provider failure”.

3 THE WORKFORCE

Innovation Aim:

To improve recruitment and retention of care staff.

Data confirms that there will be real challenges in the future in the region.

Actions:

- Develop strategic response across the region and in sub-regions.
- Consider building on a raft of initiatives that already exist [Skills for Care provide an overview].
- Address the many ideas that stakeholders have for improving workforce quality, recruitment and retention.
- Replicate Recruitment Hubs and College links.

4 MARKET SHAPING

Innovation Aim:

To develop more collaborative commissioning models, and address regional shortcomings.

There are clear areas highlighted in the Dashboard that are lagging behind national benchmarks.

Actions:

- Consider Centre for Local Economic Strategies (CLES) approach to the social care market.
- Evaluate home care / district nursing pilots (e.g. Trafford) for possible replication.
- Investigate the reasons for poor performance in relation to Direct Payment uptake, residential admissions, and learning disability employment.
- Ensure providers are involved in, and informed of, outcomes of market intelligence exercises.

5 SOCIAL CARE & HEALTH INTEGRATION

Innovation Aim:

Improve the service user experience by joining up care and support, avoiding duplication. This will also improve productivity and value for money.

The benefits of strategic integration need to be delivered locally.

Actions:

- Monitor new care initiatives [such as Trafford pilot] with aim of replicating if successful.
- Monitor Greater Manchester pooled budgets with aim of replicating if successful.
- Meet the challenge of ICT incompatibility.
- Consider a response to cultural differences between health and social care.

6 QUALITY DETERIORATION

Innovation Aim:

To drive up quality of care services by having a more co-ordinated and smarter inspection regime.

This is especially necessary given the below average quality performance across the region.

Actions:

- Develop cross-agency collaboration for inspection and agreed quality measures.
- Develop a joint approach to the sharing and addressing of quality concerns amongst placing authorities.
- Develop an approach to the sharing of intelligence across the region and across agencies.
- Commissioners and Providers to consider how reductions in the quality of care/support can be best minimised and how improved quality can be enabled.
- Develop best practice guidelines from the NW ADASS survey of Quality Assurance teams in the region.

Medium/High Priority Issues

The next three issues were of lower priority by the survey respondents, but positive responses appear to be quite feasible in all three cases. Local responses in the case of issues 7 and 8, and national responses in the case of issue 9. Collaborative work in this area could, again, serve to forge stronger links between different stakeholders in the market.

7 HIGHEST NEEDS PRIORITY

Innovation Aim:

To ensure that the Some receive information and guidance.

This is particularly important given that the situation with services being targeted at the Few, is unlikely to change.

Actions:

- Develop and agree a regional methodology for the assessment and quantification of the benefits of preventative work.
- Fully inform and regularly update clients, social workers, NHS staff and provider staff about assistive technology solutions. Improvement of information services that makes use of on-line and direct-access solutions.
- Adopt a truly multi-agency approach that tackles information sharing issues.

8 MINIMUM LEVEL OF CARE

Innovation Aim:

To develop an outcome based assessment that can encourage dynamic care delivery, that responds to user needs and enables progression for social care clients wherever possible.

Actions:

- Improve initial and on-going assessment of people with social care needs to encourage independence not dependency.
- Investigate the Trusted Assessor approach whereby providers are involved in assessment. Develop an outcome-based approach to commissioning and also, crucially, to monitoring. Encouraging the development and use of assistive technology.
- Ensuring that Public Health input is targeted so that benefits for social care clients are maximised.

9 CROSS SUBSIDY

Innovation Aim:

To respond to the national policy lead on this issue if and when it emerges.

New policy is likely to be proposed in the imminent Competition and Markets Authority report.

Actions:

- Recognise that the current situation is potentially serious and be prepared for change.
- Respond to CMA report when it emerges.

Medium Priority Issues

The last 3 issues are all high priority issues at a national level, but locally they are considered less important. There is a danger that a low priority now may lead to complacency over relatively good performance with subsequent problems further down the line. In particular, the support for carers probably warrants more focus and a higher prioritisation across the North West Region.

10 HOSPITAL DISCHARGE

Innovation Aim:

To lessen admittance to A&E from care situations, to reduce delays in discharge from hospital back to the community.

North West performance is in line with the national picture.

Actions:

- Learn from good practice elsewhere and from within the region.
- Improve practical ways to support hospital discharge [financial responsibility, equipment, assistive technology etc]
- Use Care Home Improvement Plans to help avoid inappropriate admissions.
- Attempt a whole system approach to improve hospital / community systems, probably through existing STP arrangements.

11 & 12 RELIANCE ON UNPAID CARERS & CARERS' NEEDS

Innovation Aim:

To support unpaid carers in the most effective ways.

Ignoring the development of support to carers could lead to trouble later.

Actions:

- Share best practice across the region.
- Develop information for carers, using innovative technologies as they emerge.
- Consider training schemes for carers.
- Develop a clear carers pathway.
- Review need for respite and sitting services.



Directors of
adass
adult social services
North West

To discuss this report with the
NW ADASS Programme Office please contact:

Thomas Maloney

NW ADASS Programme Director
thomasnwadass@nwemployers.org.uk
07392 197273

Andrew Burridge

NW ADASS Policy & Programme Manager
andrewnwadass@nwemployers.org.uk
07392 197575

Paul Madden

NW ADASS Senior Analyst
paul.madden@liverpool.gov.uk
07801 404 948