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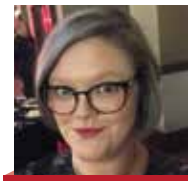
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From the Editor

Editor, Angharad Burnham talks about the importance of experts and providers coming together to collaborate and learn.

Something I notice about the social care sector is that it has a great ability to evolve and learn. It's a fundamentally collaborative sector and, whilst there are areas of siloed working, a lot of providers are eager to learn from each other and share the lessons they've learnt. Often, this is about improving services, with the aim of achieving high ratings. But one area that figures show many struggle with is the Safe key question in Care Quality Commission (CQC) inspections.

Only a small proportion of providers are rated Outstanding in this area, and it has one of the highest levels of lower ratings. Aside from potentially bringing down overall ratings, having a lower rating in Safe can make it look like a service isn't reliable. And with the constant media barrage of scandal and abuse in care, it's important the public can trust in services to care for their friends and relatives.

With this in mind, we asked Ed Watkinson from QCS to bring his extensive knowledge to the fore and share advice on how best to achieve the top rating in this key question. Ed guides us through the changes providers should be making to ensure CQC sees their service as safe, taking learning from those providers who are already achieving Outstanding in this area. Read his article on page 25.

LEARNING TO COLLABORATE

Sticking with the issues around safety of services, our article on page 36 examines the specific issues charitable social care organisations face in terms of regulation. Using the expertise of sector leaders, we break down how the Charity Commission and CQC can offer a more joined-up approach, so that providers can spend less time reporting and more time looking after people in their care.

If there's one area across the sector that requires more collaboration, it's the integration agenda. Everyone wants to reduce the difficulties faced by people going through the health and care systems, and making services work together is the only way to achieve this. The Esther Project in Sweden is aiming to reduce delayed transfers of care and put people at the very centre of the health and care pathway. The article on page 41 gives a detailed view of the way the project works and its benefits.

LOOKING AHEAD

When we are talking about learning from others, it's vital that we not only look to people who are doing things well elsewhere, but that we also examine what knowledge and skills are needed – and available – within a service. Skills for Care's article on succession planning on page 20 explores the ways that providers can utilise existing knowledge and develop people's skills in the process, so that planning for your organisation's next leaders becomes an embedded process with wide-reaching impact.

Finally, for those looking to learn about latest developments in social care, don't miss our CMM Insight events. Experts come together to share best practice, knowledge and ideas, while providers have the opportunity to take a step back from their service and discuss solutions to common issues. Visit the CMM website to find events in your area.

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Inside CQC

DEBBIE IVANOVA

Debbie Ivanova, Deputy Chief Inspector of Adult Social Care at the Care Quality Commission (CQC) shares how the thematic review of restraint is progressing ahead of its publication in Spring.

In November, Mary Cridge talked in this column about the progress of our thematic review of restraint, segregation and prolonged seclusion, and I want to use this opportunity to continue that conversation as we near the publication of the final report this Spring.

The CQC was commissioned in November 2018 by Secretary of State for Health and Social Care, Matt Hancock to look at the use of restrictive interventions. Throughout the review, we have looked at how places providing inpatient care for people with mental health issues, a learning disability, and/or autism use these interventions.

We published our interim report in May last year. It focused exclusively on the experiences of people cared for in segregation on a mental health ward for children and young people, or on a ward for people with a learning disability or autism. The report made a number of recommendations for organisations across the health and care system, including CQC. In the second half of the review, we have included visits and surveys of care services where people with learning disabilities and autism live.

At the end of January, we held our final expert advisory group for the review. It was great to have an even split between provider representatives and people with lived experience – or family members with lived experience – in the room, leading to an open and meaningful conversation. If it weren't for the time and commitment these people have put into the four expert advisory groups that we have held, and the work that surrounds this, we would not have properly understood just how the current system is failing people and the impact of that.

"The report made a number of recommendations for organisations across the health and care system, including CQC."

Families and people with lived experience led the first session at the final expert advisory group, in which we reflected on all of the other reports, recommendations and policies that have been created in this area over recent years. A quick internet search will show you just how many recommendations have been made to reduce the use of restrictive practices, yet our interim report showed that, at that time, there were at least 62 people in segregation, with 16 of those people having been in segregation for over a year.

So why are we still seeing shocking figures like these? There's a whole host of reasons that recommendations to improve the system for people with a learning disability or autism have not had an impact. They range from budget pressures to lack of staff training, and include many other reasons, some of which were discussed at the meeting.

When the final report publishes in Spring this year, we will be taking a view of restrictive practice in health and care, including the wider quality of care, and ensuring that we take a human rights approach and put the voices of people who use services at the centre of the report.

We will also be creating recommendations which hold key partners accountable for their actions, but we need everyone who has a stake in this work to look at themselves and what they can do to improve the system.

Later this year, we will also be publishing our report looking at sexual safety and sexuality in adult social care. This is another topic which needs to be talked about. In her blog in March, Kate Terroni hopes to share more about this report and its key themes.

Debbie Ivanova is Deputy Chief Inspector of Adult Social Care at the Care Quality Commission. Share your thoughts and feedback on Debbie's column on the CMM website, **www.caremanagementmatters.co.uk**

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NEWS

MAC report on immigration

Following the release of the Migration Advisory Committee's (MAC's) report on immigration, industry leaders have voiced their concerns on how it could affect the adult social care industry.

The report looks at the possible role of a points-based system for immigration and the appropriate level of salary thresholds, and provides an assessment of how different levels of salary thresholds are likely to affect a variety of outcomes, including impact on social care.

It suggests cutting the proposed salary threshold for skilled migrants from £30,000 to £25,600, but does intimate that this won't be a solution for social care employment rates.

The MAC report acknowledges that the very real problems in the social care sector are 'caused by a failure to have a sustainable funding model' which creates barriers for providers to offer competitive terms and conditions. With this in mind, the report states that, 'Although senior carers and some other roles within this sector would become eligible with the extension of the skilled worker route to included medium-skill occupations, this route is not the appropriate one to use to solve the problems this sector faces for low-skilled workers.'

Association of Directors of Adult Social Services (ADASS) Vice-President, James Bullion said the real issue is funding, noting, 'Thresholds...are largely meaningless in a sector where over a third earn the national living wage.'

Niall Dickson, Chief Executive of the NHS Confederation, welcomed reducing the salary threshold but said it won't be enough.

He highlighted, 'In both health and social care we cannot recruit and retain the staff we need now, and unless we have the right migration arrangements, we risk stretching local services to breaking point.'

Deborah Alsina MBE, Chief Executive of Independent Age, said, 'The social care sector is already under immense pressure, and heavily reliant on workers from overseas. Anything that creates a further barrier to recruiting and retaining that workforce will only make that worse.'

The full MAC report on immigration and salary thresholds is available on the GOV.UK website.

Sector Pulse Check 2019

Hft's *Sector Pulse Check 2019* report has revealed the number of social care providers who say they have been forced to cut support for vulnerable adults has doubled in the last 12 months as a direct result of financial pressures.

One in five organisations reported offering care to fewer individuals to balance the books (a rise of 12% from 2018), with 95% citing rising wage bills as the main drain on resources.

A third of providers (33%) also cited having to shed staff in the past year, while almost half (45%) have closed down some parts of the organisation and/or handed back contracts. 52% expected to have to do so in the future.

Hft's *Sector Pulse Check 2019* report, carried out by independent economics and business consultancy Cebr, focuses primarily on learning disability providers. Based on survey analysis from social care providers, it provides an annual snapshot of the adult social care sector's finances over the past year as well as an indication of how providers anticipate the next twelve months will progress.

This year, 43% of providers (compared to 11% in 2018) said they had witnessed a negative effect on the quality of care they were able to provide. They cited an increase in complaints, worsening Care Quality Commission (CQC) accreditations and a decrease in morale as the most severe indicators of a decline in standards.

The report also highlighted:

- Providers are taking action to promote positive mental health within their organisations with 67% of respondents sign-posting to mental health services. Other steps taken include implementing mental health awareness training (66%) and introducing relevant employee benefits packages (59%).
- The sector recognises the benefits of technology with 76% of providers saying the use of technology enhances the lives of the people they support. However, while three quarters of providers use technology as part of their services, 81% say they are not using it to its full potential.
- The social care workforce shares a common motivation: 78% of providers believe staff embark on a career in social care to make a difference to the lives of vulnerable adults.

Billy Davis, Public Affairs and Policy Manager for Hft, said, 'As our Sector Pulse report shows, the sad reality is that the social care sector has run out of options. While in the previous report providers were focusing on streamlining through internal efficiency savings, we can now clearly see that cuts are affecting people, not just processes.'

Hft is now calling for the Department of Health and Social Care to bring forward their long-overdue proposals on reforms for the long-term future funding of adult social care.

Minimum Price for Homecare

The United Kingdom Homecare Association (UKHCA) has calculated the Minimum Price for Homecare for 2020. Widely recognised within the social care and health sectors in all four UK administrations, councils in England are directed to UKHCA's methodology in the Department of Health and Social Care's *Care and Support Statutory Guidance*.

The new recommended Minimum Price for Homecare, which sits at £20.69 per hour, should take effect from 1st April 2020, when the National Minimum Wage and National Living Wage increase. This is an increase from £18.93 per hour for 2019.

The new Minimum Price for Homecare includes enough to cover:

- £8.72 for care workers' contact time.
- £1.70 for travel time.
- £1.36 for mileage costs.
- £5.20 for running the business.

Other costs include National Insurance (NI) contributions and profit.

Local conditions, calculated on the minimum legal pay rate, are usually likely to mean the costs are higher than UKHCA's Minimum Price for Homecare.

In calculating this rate for April 2020 to March 2021, UKHCA made changes to its calculations from the previous year to ensure it is in line with current procedures. These changes include assuming that all care workers, including the 11% of the workforce who are under 25 years of age, receive at least the statutory National Living Wage, and increasing sick pay from 0.5% to 2.9% of gross pay.

A full update and further breakdowns are available on the UKHCA website.

Matt Hancock faces legal challenge

The Equality and Human Rights Commission has launched a legal challenge against the Secretary of State for Health and Social Care for the continued failure to ensure people with learning disabilities are living in appropriate accommodation.

This follows the Commission's concerns about the rights of people with learning disabilities and autism who are detained in secure hospitals, often far away from home and for many years.

The Commission has sent a pre-action letter to Mr Hancock, arguing that the Department of Health and Social Care (DHSC) has breached the European Convention of Human Rights (ECHR) for failing to meet the targets set in the Transforming Care program and Building the Right Support program.

Following discussions with DHSC and NHS England, the Commission states it is also not satisfied that new deadlines set in the NHS Long Term Plan and Planning Guidance will be met. This suggests a systemic failure to protect the right to a private and family life, and right to live free from inhuman or degrading treatment or punishment.

DHSC has 14 days to respond to the pre-action letter. Alternatively, the Commission has offered to suspend the legal process for three months if DHSC agrees to produce a timetabled action plan detailing how it will address issues such as housing and workforce shortages at both national and regional levels.

Commissioning of disability services

A fresh approach to the strategic commissioning of disability services is urgently needed, says Voluntary Organisations Disability Group (VODG).

Relationships between statutory bodies and voluntary sector organisations must be strengthened so that positive outcomes for disabled people can be achieved.

This is according to a report published by VODG, *Commissioning for a vibrant voluntary disability sector: the case for change* which draws upon collective experiences across the VODG membership.

The report explores some of the challenges associated with the commissioning of disability services as reported by voluntary sector providers.

These include navigating complex procurement processes to compete for low-priced contracts, having to subsidise services from charitable funds, and in some cases being forced to hand back contracts because of funding pressures.

The report also examines what good practice between statutory bodies and the voluntary sector should look like, offering recommendations for local authorities and clinical commissioning groups to support the effective delivery of services.

Dr Rhidian Hughes, VODG's Chief Executive said, 'We need to strengthen strategic partnerships...As our report demonstrates the voluntary sector makes a significant contribution to ensuring that the rights and entitlements of disabled people are met – we hope that a fresh approach to strategic commissioning will uphold, and not hinder, that contribution.'

New Chair of Health and Social Care Select Committee

Jeremy Hunt – Conservative MP for South West Surrey, and former Secretary of State for Health and Social Care – has been elected as the new Chair of the Health and Social Care Select Committee.

Following the results, Mr Hunt tweeted about his ambitions for his time in the role. He wrote, 'For my last six months as Health Secretary, social care was formally added to my responsibilities but it was not long enough to bring forward reforms or – more crucially – a funding settlement for social care.

'That is what I will be pressing for, because the NHS will continue to fall over every winter until we fix social care, risking both patient safety and staff morale.'

The secret ballot of MPs took place at the end of January and votes were counted under the Alternative Vote system.

Agincare expands to Midlands

Agincare has started an expansion into the Midlands for its residential homes, with the acquisition of three Derby care homes from Derby City Council.

Agincare already has a national presence with its homecare and live-in care services but its care homes have always been mainly located in the southern region of England.

Derby's Foylebank Care Home (formerly Raynesway View), Queensferry Court (formerly Merrill House) and Coleridge House are now the northernmost members of Agincare's portfolio of more than 20 care and nursing homes.

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Loneliness Annual Report 2020

The Department for Digital, Culture, Media and Sport has published its first *Loneliness Annual Report*. This looks at tackling loneliness in the UK and provides an update on the progress made since the publication of the cross-government Loneliness Strategy in October 2018.

The report states that Government's goal remains to significantly reduce the number of lonely people over the next ten years, noting that, 'Doing so will require long-term action from government, business and civil society and a change in public attitudes.'

It calls for everyone to play their part in helping to reduce loneliness, to make it OK to talk about loneliness and to support society to accept the issue.

Also explored are areas where Government has made significant changes to the way loneliness is understood and approached in the country, detailing the steps taken, and the allocated funding.

The report shares the next big areas of focus for Government, which are:

- The need for more information and communication about loneliness and the activities which are available to reduce it.
- The need for further policies targeted at tackling children and young people's loneliness – young people report struggling with loneliness more than any other group, but targeted interventions and policies are currently relatively sparse.
- The need to tackle loneliness through place – strengthening community infrastructure and assets, and growing people's sense of belonging.

Further details on how Government intends to tackle these specific issues will be released later this year.

The full report can be found on the GOV.UK website.

Emergency admissions for people with dementia

Data published by Alzheimer's Society reveals more emergency admissions are being made for people with dementia.

The figures show over 379,000 emergency admissions in England for people with dementia in 2017/18, an increase of 35% from 2012/13.

The number of people with dementia who stay in hospital for up to a year after an emergency admission in England has also risen by 6% since 2012, with 40,000 people with dementia remaining in hospital for longer than a month in 2017/18.

According to Alzheimer's Society, the rising figures mean more than half of all people with a dementia diagnosis in England went through emergency admission to hospital in 2017/18, many multiple times.

The charity estimates this increase in emergency admissions for people with dementia cost the NHS over £280m. On top of this, the cost of the 40,000 people spending between a month and a year in hospital in 2017/18 was over £165m.

While the ageing population may be accountable for some of the increase, Alzheimer's Society suggests much of the increase could be down to difficulties faced by the social care sector, particularly given the limited number of care homes able to provide specialist dementia care.

The charity is demanding £8bn per year allocated in the Spring Budget to stabilise the social care system, and for cross-party talks to begin immediately.

The report can be downloaded at www.alzheimers.org.uk.

IN FOCUS

Better Health and Care for All

WHAT'S THE STORY?

A new review, *Better Health and Care for All*, has highlighted evidence on the realities of health and social care services for people with learning disabilities.

Published by the National Institute for Health Research (NIHR), the review brings together 23 published studies funded by the NIHR examining aspects of health and social care services for the more than one million people in the UK with a learning disability.

People with learning disabilities generally have poorer health and die earlier than the general population and work is needed to improve how services are organised and delivered, says NIHR.

The review considers the evidence produced by studies in four key areas of health and care:

- Identifying health risks.
- Keeping well in the community.
- Staying well and safe in hospital.
- Supporting positive behaviour.

WHAT ARE THE FINDINGS?

Little more than half of people with learning disabilities are having annual health checks with their GP, even though research shows that these checks can improve their health and care, and address health problems that may result in hospital admissions and poor health in the long term. This is an important finding, given that evidence also showed people with learning disabilities are more likely to be admitted to hospital as emergency cases, and that swallowing problems are common among people with learning disabilities. Health checks and GPs assessing the need for meal-time support could reduce these risks.

In terms of the quality of people's support, research showed only one third of people in community group homes got good support to stay active and social. With other studies showing that supporting staff to find better ways of engaging and working with residents can reduce challenging behaviour, it's vital that the quality of people's care is good.

However, general hospitals seemed to vary greatly in this respect. Many hospitals lack systems to effectively flag-up patients with learning disabilities, and family carers are often not involved in care processes. Though notably, learning disability nurses were found to make valued contributions to care.

WHAT DO EXPERTS SAY?

Dr Jean O'Hara, former National Clinical Director for Learning Disabilities at NHS England, said, 'We know that people with learning disabilities still experience poorer health outcomes and are more disadvantaged than others. This is why we have made reducing health inequalities and improving quality of care for people with learning disabilities one of the top priorities in the NHS Long Term Plan....[research] evidence can give us insights into the services and support needed for every individual to have the best chance of living a full and happy life.'

Calls for recognition for social care

Ahead of the 2020 Budget, Care England has called for recognition for social care to be at the heart of the new Government.

Professor Martin Green OBE, Chief Executive of Care England, said, 'The Prime Minister has been vocal in his support for finding a long-term, sustainable solution for adult social care.

'The first step is the recognition that social care is intrinsically linked with the NHS; the main input in the delivery of adult social care services is labour yet the failure of successive governments to fund appropriately the increases to the National Living Wage has impinged upon social care providers' ability to reward their most valuable resource; the workforce.'

The representative body points out the social care sector employs approximately 1.6 million people, more than the NHS, thus being a hugely important part of local economies and communities. Staff costs account on average for about half of total running costs for adult social care providers.

Furthermore, the increases in the National Living Wage in recent years have, at times, exacerbated the workforce crisis that currently persists in the adult social care sector. An increasing proportion of the workforce is now paid at or around that minimum level and the pay differential between care workers with less than one year of experience and those with more than 20 years of experience has reduced to just £0.15 an hour.

Martin Green continues, 'We need to have parity of esteem between the NHS and social care. In terms of workforce this means better pay. The latest NHS pay deal...only serves to further emphasise the lack of parity...It is incumbent upon Government to ensure that such increases in the National Minimum and Living Wage are reflected in the fees paid to care providers.'

The Low Pay Commission, responsible for National Living Wage rates, has also called upon Government to recognise its role, saying, 'In the sectors which Government itself funds – social care and childcare – sufficient funding is necessary to meet the cost of the rising NLW.'

Rapid response teams

Under new plans outlined by the NHS, expert rapid response teams will be on hand within two hours to help support older people to remain well at home and avoid hospital admissions.

The teams will give those who need it fast access to a range of qualified professionals who can address both their health and social care needs, including physiotherapy and occupational therapy, medication prescribing and reviews, and help with staying well-fed and hydrated.

Older people and adults with complex health needs who have a very urgent care need, including a risk of being hospitalised, will be able to access a response from a team of skilled professionals within two hours, to provide the care they need to remain independent.

A two-day standard will also apply for teams to put in place tailored packages of intermediate care, or reablement services, for individuals in their own homes, with the aim of restoring independence and confidence after a hospital stay.

Local health service and council teams will begin the roll out of Urgent Community Response teams from April, as part of the NHS Long Term Plan to support England's ageing population and those with complex needs.

Backed by £14m of investment, seven accelerator sites will be the first to deliver the new standards for care.

They are:

- Warrington Together (Cheshire and Merseyside STP).
- West Yorkshire and Harrogate Health and Care Partnership (Kirklees).
- Leicester, Leicestershire and Rutland.
- Cornwall.
- Buckinghamshire, Oxfordshire and Berkshire.
- South East London.
- Norfolk and Waveney.

Safeguarding guidance for charities

The Government has launched an online portal that will strengthen its support to charities, including those working in the field of adult social care, handling safeguarding concerns or allegations.

The portal will help charities correctly manage their concerns, identify the right people to contact if needed and access helpful resources and advice.

A combined £1.2m investment will ensure the portal will be promoted by six organisations across England. These are Voluntary Organisations Network North East (VONNE), Action with Communities in Rural England (ACRE), Voluntary Action Leeds (VAL), Social Care Institute for Excellence (SCIE), The Federation of London Youth Clubs, and National Association for Voluntary Community Action (NAVCA).

The funding has also enabled the National Council for Voluntary Organisations to bring together organisations to develop a series of free, high-quality factsheets, practical tools, podcasts and videos to promote a good safeguarding culture in charities.

Orchard Care Homes

Sandstone Care Group has acquired three homes from Orchard Care Homes in the North West of England.

The sale of St Helens Hall and Lodge, Longridge Hall and Lodge and Fleetwood Hall follows the decision last year by Orchard Care Homes to reduce its portfolio by around 25%.

All Orchard staff at these homes are transferring across to Sandstone Care.

Sandstone has also recently opened its first purpose-built care home in Newtown, Powys, and expects to acquire and build further homes during 2020.

Reardon Court

Reardon Court in Cosgrove Close, Winchmore Hill has been granted planning permission to build a specialist care home designed to help older people live independently for longer.

The development will provide 91 homes for affordable rent in blocks up to four storeys high. Consisting of mainly one-bedroomed self-contained flats, the accommodation will be equipped with a kitchen, bathroom and living space.

There will also be a courtyard with trees, communal tables and chairs, and a Petanque ball game court.

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Health and Care of People with Learning Disabilities

NHS Digital has published information on the health and care of people with learning disabilities in 2018-19.

Health and Care of People with Learning Disabilities: Experimental Statistics: 2018 to 2019 examines trends in the key health issues for people who have a learning disability according to their GP records. It also contains information on how this data compares to that of people without a recorded learning disability.

Looking at data from participating practices, which amounts to around 54% of people in England with a learning disability, the report investigates rates of mortality, life expectancy, and prevalence of certain health conditions.

Notably, the report states that, 'Based on 2018-19 data, males with a learning disability have a life expectancy at birth of 66 years. This is 14 years lower than for males in the general population.' For females, the report found that those with a learning disability have a life expectancy of 67 years, 17 years lower than females without a learning disability.

The report adds, 'There has been no statistically significant change in life expectancy for patients with a learning disability between 2014-15 and 2018-19.'

It also revealed that epilepsy was 26 times more common in people with a learning disability than would be expected for an equivalent cohort of those without a learning disability. The prevalence rates for asthma, hypertension and non type I diabetes have all also seen a significant increase since the 2017-18 data was collected.

Cervical cancer screening for those with a learning disability does appear to have improved, with more people than ever receiving a cervical cancer screening in 2018-19, although this rate is still much lower than uptake from those who do not have a learning disability. The full report is available on the NHS Digital website.

Heritage Care rebrands

Reflecting its change to one charity delivering different services, Heritage Care has announced it will bring its portfolios under one name and logo; as of April 2020, the charity, which incorporates Community Options, will be known as Ambient.

The charity delivers services to vulnerable adults. It operates in over 140 locations, providing over 30,000 hours of care weekly.

The rebrand is part of the charity's five-year-plan which reasserts its commitment to delivering high-quality care.

Director of Marketing and Communications, Davina Sellick said, 'Our broad range of expertise means we can fully support people to meet their specific, individual needs and to care for people with multiple and complex diagnoses – but this message was difficult to communicate whilst operating under multiple names.

'Through the rebrand, we aim to raise awareness and improve understanding of how our combined services can meet individual requirements. One name, one logo and one website enable us to better articulate how we can expertly support those in need.'

Skills for Care Accolades

The winners of the Skills for Care Accolades 2020 were announced at an event hosted by *Strictly Come Dancing* star, Anton Du Beke in January.

Now in its 17th year, the Accolades celebrates innovation and excellence in workforce development.

Skills for Care's Interim Chief Executive, Andy Tilden said, 'It was a privilege to share in the delight of all our winners who all showed some really smart thinking in how they support their workforce to deliver high quality services.

'Given the high level of competition, all our finalists did brilliantly to make their shortlists, and it was inspiring to hear from them how they really support the learning and development needs of their workforces, which results in better services for the people they work with.' Read more about the Accolades on page 48.

Social Care Digital Pathfinders grant

Sixteen organisations that provide and commission adult social care services are to receive a share of a £4.5m Social Care Digital Pathfinders grant from NHS Digital to enable them to roll out their local digital projects on a wider scale.

The grant supports products and services that have already been piloted in small, local areas with the view to implementing them on a larger, more national scale.

The successful Digital Pathfinders will now commence a 13-month implementation phase.

Projects predominantly look at standardising information and developing digital ways of sharing that information between multiple health and social care organisations.

The investment is managed by NHS Digital as part of the NHS' Digital Transformation Portfolio.

It supports Matt Hancock's, the Secretary of State for Health and Social Care, vision for interoperability and openness, open standards and appropriate infrastructure.

Health Minister Nicola Blackwood said, 'Bridging the technology gap between the NHS and social care is a central part of achieving a health and care service that is fit for the future.

'This £4.5m investment will support local areas to improve information sharing across services, ensuring people avoid hospital unless absolutely necessary and helping everyone live independently for longer.'

Examples of the pathfinder projects to be provided with the funding are:

- South Gloucestershire Council and London Borough of Sutton, which are both working to recognise care homes as 'Partners in Care' by developing the 'digital red bag'. This involves providing care homes with access to the existing Local Health and Care Record (LHCR) portals, and allowing information to be shared across GPs, hospitals and other local organisations to support continuity of care. This new initiative will mean that care homes can also view and update those records.
- Wirral Council, which is working to scale up the Digital Discharge process for hospital patients who require care and support when they are discharged. Their system sends information directly into a local authority's social care system ahead of the patient being discharged and, where there is a change in circumstances, removing the need for assessment (known as Assessment, Discharge and Withdrawal notices).

A full list of the projects awarded the Social Care Digital Pathfinders grant is available on the NHS Digital website.

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CPA appoints new Chair

Lisa Lenton, Director at the Association for Real Change England (ARC England), has been appointed Chair of the Care Provider Alliance (CPA).

Bringing together the ten main national associations which represent independent and voluntary adult social care providers in England, the CPA works to represent the sector and ensure a coordinated response to the major issues that affect it.

Commenting on her appointment, Lisa said, 'I'm delighted to be the current chair of the CPA. 2020 will be a transitional year indeed, not only for our country as we form a different relationship with the EU, but also for our sector as wider domestic issues take shape under the new government.

'Working together with our member associations, we continue to develop effective ways to engage and influence policymakers, national bodies, commissioners, regulators and other key influencers. In the past few months, with support from the Department of Health and Social Care, the CPA has undertaken a significant project alongside colleagues at The Association of Directors of Adult Social Services to develop a set of useful resources and tools to support care providers in England prepare during the transitional period. Our work to assist the sector through the production of these resources will be hugely helpful to providers as they continue to work tirelessly to support people who access their services.'

Advanced Care Research Centre established

The University of Edinburgh and Legal & General have announced a major partnership to improve understanding of care in later life and to revolutionise how it is delivered.

The collaboration will establish the Advanced Care Research Centre (ACRC), a seven-year multi-disciplinary research programme and the first of its kind in the UK.

Combining research across fields including medicine, care professions, life sciences, engineering, informatics, data and social sciences, the Centre will enable data-driven, personalised and affordable care that delivers independence, dignity and a high quality of life for people living in their own homes or in supported care environments.

Professor Peter Mathieson, Principal of the University of Edinburgh said, 'As our population ages, so we need to develop innovative new approaches to provide individually-tailored care.

'This is the big challenge that the partners will address, bringing to bear pioneering research from the brightest academic minds across multiple disciplines to deliver creative and trusted solutions to solving real world problems.'

Visit www.ed.ac.uk for more information.

Healthwatch annual report

In its annual report to Parliament, Healthwatch England revealed it supported over 336,000 people to share their story about health and social care.

These views resulted in over 7,200 recommendations to services about the improvements that people would like to see.

Healthwatch's work has also shown that 42% of people support raising taxes to pay for social care, with 18-24 year olds the most likely to support paying for compulsory social care insurance, and older age groups less willing to save for social care.

The report also shows how the organisation is using people's views to improve existing and future services by highlighting issues such as:

- The length of time people have to wait for dementia care, and the need for councils to regularly review the level of support people need.
- The challenges some carers face when it comes to getting help and the impact this can have.
- People's desire for more information and advice to help them plan for care in old age.

St Andrew's Court

Exemplar Health Care has officially opened its specialist nursing care home, St Andrew's Court in west Hull, near Gipsyville.

The care home has undergone a £1.25m refurbishment to meet the complex needs of its adult service users.

It can support up to 20 adults who live with complex conditions including dementia, mental health conditions, physical and neuro-disabilities, brain injury and stroke.

The home comprises 18 bedrooms, each with an en-suite bathroom, and includes two dining rooms, several communal living areas and a landscaped garden designed by young local volunteers from Youth in Nature, a lottery-funded wildlife organisation.

The home also benefits from Exemplar Health Care's reablement pathway, OneCare, which is a two-bedroom house adjacent to St Andrew's Court where individuals are supported to live more independently through rehabilitation and enabling activities.

Care UK

Care UK has opened a new care home in Bristol – the first of five new homes it will open this Spring.

Trymview Hall provides full-time residential and dementia care for up to 66 local people and has been designed to enable residents to live active and fulfilled lives, while also promoting independence.

Moorlands Healthcare

OakNorth Bank has lent £2.3m to Moorlands Healthcare Limited, a care home operator that's part of the newly-incorporated My Choice Healthcare Group. The finance will be used for the acquisition of Harewood Park Care Home, located on the edge of Cheadle town centre in Staffordshire.

The home offers residential and nursing care for young adults between 18 and 65 years old with mental health difficulties, learning disabilities and brain injuries.

Moorlands Healthcare Limited will refurbish and operationalise three additional rooms at Harewood Park, increasing its capacity to 37 rooms.

The King's Fund strategic priorities

The King's Fund has announced its strategic priorities for 2020-24, looking at specific areas where it believes it can maximise its impact. Working with staff and people from across the health and care system, the organisation has chosen three aims for the next five years. These are:

- To drive improvements in health and wellbeing across places and communities.
- To improve health and care for people with the worst health outcomes.
- To support people and leaders working in health and care.


SHAPING
THE FUTURE:
Top tips for succession planning

Succession planning is an essential part of running any service, but how many organisations in our sector actively do it? Oliver French, Project Manager for Employer Engagement at Skills for Care explores the very real need for succession planning in adult social care and says it's as much about developing the next generation of leaders, as it is about nurturing the wealth of existing talent.

How did you arrive in your current post at work? Was it a move that you had planned and prepared for? Or was it more immediate, with some quick 'learning on the job' required?

However you answered the questions above, one thing is guaranteed – you won't have forgotten how it felt to walk through the door on your first morning in a new role. The moments when we make a change, taking on more responsibility or a wider remit, are formative; they come with a mix of excitement, pride and, more often than not, a certain degree of fear.

OPPORTUNITY VS CHALLENGE

No amount of succession planning will remove that conflicting feeling of a step-up career-wise being both an opportunity and a challenge, but it will prepare someone, ensuring they have the right capabilities and skills to manage the increased responsibility, whilst supporting themselves and their teams.

Yet, for many registered managers in adult social care, it remains the case that moving into their first manager role was sudden and unplanned. For every great example of succession planning we see, there are also managers who will tell us, 'I was not ready at all. Suddenly the buck stops with me, and I just wasn't prepared for the shock of that.'

Care Quality Commission (CQC) inspection data shows that the presence of a registered manager in a service has a direct impact on the quality of care. We also know from data produced by Skills for Care that as many as 7,000 registered managers might retire within the next 15 years, and that annual turnover (24%) and vacancy rates (12%) for registered managers are already high.

As a sector, we must make succession planning a priority. And if it's done well, the benefits reach far beyond simply being able to answer, 'Who's next?'.

IT ISN'T ALL ABOUT WHO'S NEXT

It would be a mistake to think of succession planning as being only about the development of your next manager or filling a gap. In fact, this can even be unhelpful. The benefits for a manager, service, organisation or owner can be much wider.

When we speak to successful managers, they talk as much (if not more) about the talents of the team around them as they do about their own experiences.

Put simply, managers need good deputies. Every manager should have the opportunity to step away from their service, whether that's to pursue their own learning and development, meet other managers via a local Registered Manager Network, build relationships within their local community, or take a holiday.

This means having a deputy, care co-ordinator and team around them to whom they can confidently delegate. We must recognise that successful succession planning isn't just about meeting the future needs of a service, but also plays a key role in ensuring managers have the support they >

> need in the here and now.

Supporting the development of staff is also an important element of attracting and retaining the right staff. One manager told us, 'Part of the reason for my move [of organisation] was to join a service where I felt I could progress further. I believe my organisation could see I wanted to progress and wanted ultimately to become a registered manager.'

Even where there isn't a post (yet) for someone to step into, supporting their development will keep them positive and motivated.

As well as this, employers must bear in mind that talented staff will always be in high demand, so providing appropriate career development opportunities is a key part of encouraging staff to stay with your business, in turn improving standards of care. Failing to support and develop talent will disempower individuals and increase the likelihood of them leaving your service.

Taking all of this into account, perhaps the best news regarding succession planning is that supporting staff in this way doesn't have to be complicated and doesn't always involve financial investment.

CREATING YOUR PLAN

Whilst some services have a clear approach to succession planning mapped out, many don't. Skills for Care's Guide to developing new managers and deputies provides practical examples and templates to help employers. To begin creating a plan for your business, consider these approaches.

Identify talent

Not every future manager knows what they want to do when they join the care sector, so providing opportunities to allow people to expand their role and experience different areas of care management is a great starting point.

Whether someone progresses to a manager role in the future or not, you may find that identifying various people's talents enables you to find the right person for an existing or new role in another area of your service:

Develop talent

Once you've identified the talent in your service and see someone's potential in management, helping them to develop this talent is essential; this can be the first step towards them coming out of their comfort zone, taking on new responsibilities and widening their abilities.

Lots of the skills that deputies and managers need can be developed through informal, day-to-day, opportunities. These opportunities can be broken down into:

- Learning from others: buddying, shadowing and mentoring.
- Sharing expertise: creating champions for areas of work, developing others (e.g. sharing skills) and becoming a buddy.
- Taking a lead: leading a project or management task, or taking responsibility for supervising another member of staff.
- Growing contacts: visiting another service, networking, or chairing a meeting.

Senior management should ensure that these opportunities are available to employees who are coming up the ranks, so that they are prepared for the additional responsibility that might come with their next role.

Make use of learning programmes, standards and qualifications

When someone has demonstrated ambition, drive and potential through informal opportunities it's time to build on their experience and complement this by encouraging them to undertake learning programmes, induction standards and qualifications.

Skills for Care has published a recommended development route for managers which sets out some of the programmes and qualifications available. This also makes links to funding available to support these.

What each of these steps represents is valuable and important in its own right. Individuals need the time to make the most of each step. With that in mind, anyone thinking about succession planning should carefully consider:

- Planning ahead: think early about who has the potential to be a future manager and the support they need. Thinking about the process of supporting and developing someone should start long before they become a manager.
- Raising aspirations: when you think about who has the potential to progress, don't fall into the trap of only looking at those who tell you they want to progress. Different people will need different types of encouragement.
- Not leaving things to chance: promoting staff based on their length of service or their achievements in an earlier role is unlikely to instantly result in them being a good manager. Even the most committed and experienced staff will need to be supported, and having a good career plan will help with this.
- Implementing learning and development plans: Skills for Care doesn't advocate any shortcuts for those wishing to become a registered manager. It's not a role that you can effectively prepare for through a short course or something similar. It takes time and planning, and these should be factored into any succession plans you might make.

SEEING THE WHOLE PICTURE

Irrespective of our own experience of coming into a role, as employers, managers and a sector we have a responsibility to think about and lead succession planning.

Far from being only about 'Who's next?' or filling a gap, succession planning is also about ensuring our existing managers have the support they need; that our staff are motivated; and that we're providing the best care we can.

Opportunities to develop staff don't have to cost a lot (or anything) and even if someone doesn't go on to become a manager, identifying talent and developing it provides important benefits. Succession planning is an activity no provider can afford not to do. **CMM**

Oliver French is Project Manager for Employer Engagement at Skills for Care. Email: **oliver.french@skillsforcare.org.uk** Twitter: **@skillsforcare**

How do you ensure your business is in the right hands for the future? What impact do you find succession planning has on staff retention? Share your experiences on the CMM website, where you can also leave feedback on this article, **www.caremanagementmatters.co.uk**

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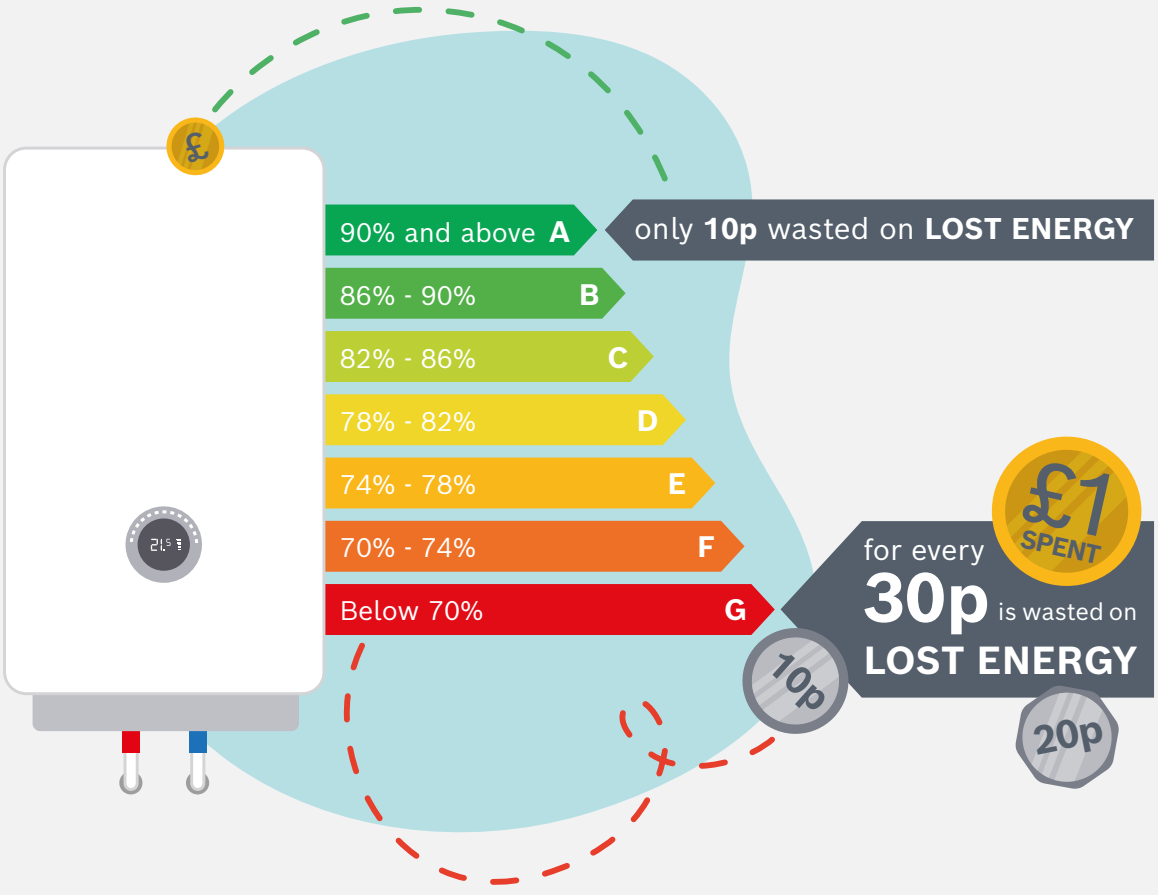

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Charlie Mason
Registered Manager and Director, Summerhayes Care Home Ltd

Overall Outstanding

Works with Care homes and Live in Care Services

Safe	Outstanding ☆
Transparency and accountability of service gives assurance to regulators and families	
Effective	Outstanding ☆
Care Routines reduce errors and missed care by receiving real time updates on completed tasks	
Caring	Outstanding ☆
Connecting the community of care including GP and Healthcare Professionals	
Responsive	Outstanding ☆
Encourages people to be more involved in decisions regarding care, connecting the community of families and professionals.	
Well-led	Outstanding ☆
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REALISING THE IMPOSSIBLE: Achieving Outstanding in Safe

It's a widely acknowledged fact that getting Outstanding in the Care Quality Commission's (CQC's) Safe key question is notoriously difficult. In fact, many providers find it is their lowest-rated area. Here, Ed Watkinson from Quality Compliance Systems (QCS) offers his insider knowledge on how to achieve the elusive top rating.

As any registered manager knows, achieving an Outstanding rating in each of CQC's five key questions is far from straightforward. In fact, in the Safe category, CQC data suggests that it's almost impossible.

CQC's *State of Adult Social Care Services* study provides a summary of every inspection carried out between 2014 and 2017. Astonishingly, it revealed that under 0.5% of providers in the UK achieved an Outstanding rating for the Safe key question. With 23% of homes also rated Requires Improvement for Safe, it's fair to say that the vast majority of care providers fare much worse in this category than they do in others.

THE INSPECTOR'S PERSPECTIVE

But why's it so difficult for providers to score highly in the Safe key question? Well, it's likely because CQC draws a clear link between safety and the outcomes for those using the service. In CQC's eyes, if a provider isn't delivering a safe service, then the outcomes for clients will most likely be negative.

When a CQC inspector checks a practice against the Safe key line of enquiry (KLOE), >

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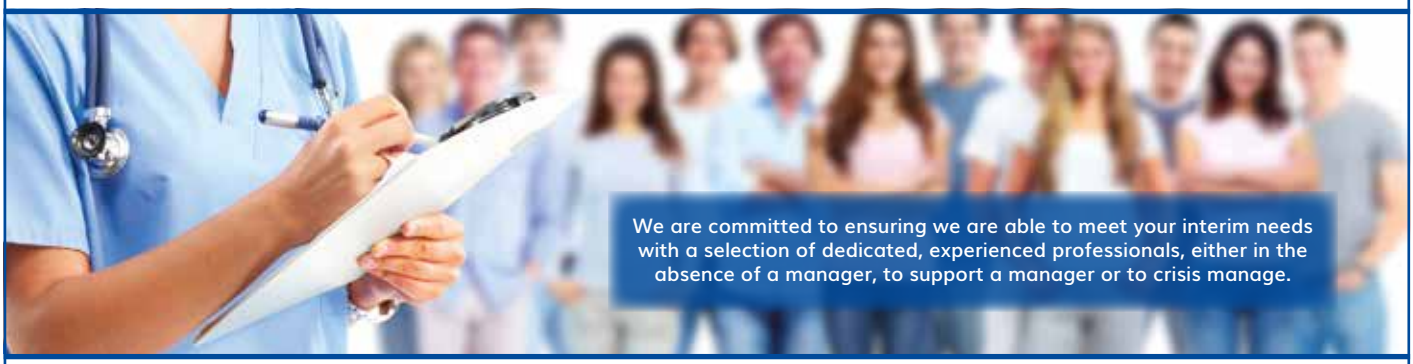

- Are you struggling to employ a manager to register with your service?
- Are you vulnerable moving towards your CQC inspection or had an inspection report showing non-compliance?
- Are you unable to find the right manager to correct the issues raised in the short time available?

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> the evidence they will assess is much more tangible than in other categories.

Inspectors don't use a sliding scale to assess safety; a practice is judged to be either safe or not. Moreover, a provider's infection control policy either passes muster or doesn't. While it wouldn't be correct to say that inspectors make a binary decision, there's little room for manoeuvre, and nor should there be.

This begs several questions. Is it possible to achieve an Outstanding rating under the Safe question, and, if so, how is it done? As a former inspector and a current adviser to QCS, it's a question I'm often asked by registered managers.

"Those who are Outstanding in the Safe category do things 'with' clients, not 'to' them."

Being on top of policies and procedures, and using systems to support improvement, is often the difference between a provider achieving an Outstanding rating and not, and, while it's far from easy to be graded as Outstanding, if managers and care workers are prepared to learn from the few stellar providers who have excelled in this category, it can be achieved.

MAKING CONNECTIONS

Take, for example, the first KLOE of the Safe question, which assesses whether the systems, processes and practices in place keep service users safe from abuse.

The first point to make is perhaps an obvious one: any registered manager striving for an Outstanding rating needs to have put in place the basic building blocks to be considered Good. That means implementing a set of watertight policies and procedures and ensuring that staff not only understand them, but actively embrace them. Often, providers using technology to support improvement will reap the benefits, gaining extra insight and fresh perspectives around best practice.

Safeguarding is a broad term and expert opinion can help with getting to the nub of what it really is. Most of all, it's about getting the message across to front-line care workers that safe services provide person-centred support. This means involving clients in their own care as much as possible – those who are Outstanding in the Safe category do things 'with' clients, not 'to' them.

Once the foundation blocks are laid, what separates an Outstanding service from a Good one is a transparent and co-productive approach to safety – and I don't just mean promoting openness within a service. Outstanding-rated providers have formed close relationships with their local authorities, too.

I would advise any registered manager who doesn't have a close relationship with their local authority to get to know its safeguarding team and ask their advice on how to follow best practice.

Why? Well, before CQC carries out an inspection it's common practice to contact the local authority to find out whether the service has been in touch or raised alerts appropriately. In the eyes of CQC, an endorsement from a third-party will show the service in a much better light than any evidence it puts forward itself. In contrast, CQC takes a dim view of providers that adopt an insular approach and try to manage problems themselves.

EMBRACING RISKS

Services that don't see the value in co-productivity tend not to receive an Outstanding grade in the Safe classification. Inward-looking homes often fail to manage risk properly, striking the wrong balance between risks to clients and individual freedoms. Many favour a risk-averse approach where everything a client does is seen as a risk, either to them, to staff, or to the reputation of the service.

This approach may eliminate risk altogether, but in doing so, the provider is not meeting CQC expectations. CQC expects people who use services have a right to live full and active lives. In this respect, the best services look creatively at how they can empower people to do what they want. And if this carries an element of risk, an Outstanding provider will seek innovative ways to mitigate it, so it becomes an acceptable risk.

RECOGNISING ROLES

Outstanding care practices – in the words of CQC – also employ the right number of 'suitable staff' who not only 'support clients' but also 'meet their needs'. Again, this isn't an easy balance.

So, what's the solution? Take a step back and clearly assess the needs of the people using the service. Registered managers should focus on the challenges faced and then ask themselves how many staff they need to provide Outstanding care.

The best providers recognise too that staff levels and the number of people using the service constantly fluctuate, as do the needs of each client. In this ever-changing environment, great care providers demonstrate dynamism and responsiveness to provide world-class care. As a result, many use dependency tools to accurately gauge numbers, and carry out regular person-centred care reviews.

That said, I believe it would be a mistake to wholly rely on dependency tools. Registered managers must recognise the role of staff and clients – this is the only way they can holistically assess a client's changing needs.

To achieve an Outstanding rating in the Safe domain, providers need to also involve family in a person's care. If the client is isolated, or does not have any family, Outstanding practice is evidenced by >

> providers who go the extra mile and seek out advocates to help.

Taking this one step further, CQC really appreciates it when care workers involve people in their own care plans. This is perhaps best illustrated in 'the proper use of medicines' KLOE, which assesses 'how medicines are ordered, transported and disposed of'.

Homes that are considered Outstanding in the medication process are those that put the person receiving the medication in control. That means empowering them to manage their own medication – if they have capacity and wish to do so.

This doesn't mean the care home divorces itself from the entire medication process. That would miss the point. Instead, Outstanding providers are always on hand to provide tools, resources and support to enable their client to effectively manage their medication. Best of all, this promotes independence and helps the client live as full a life as possible.

ACCEPTING RESPONSIBILITY

Demonstrating a culture of collaboration within a service is also critical when it comes to preventing and controlling infection in a care home. Outstanding care organisations share responsibility and ensure that everyone is fully aware of the environment in which they work.

I've inspected many facilities where staff have walked past an area that's not clean. When I asked them why they walked by, they told me that it wasn't their job to keep the home clean. That's entirely the wrong attitude. The CQC view is that it's everyone's responsibility to ensure cleanliness. On a wider note, it's about engendering an atmosphere where everyone does everything in the service. This paves the way for Outstanding hygiene and cleanliness.

On the flipside, I've also inspected homes where infection prevention measures have gone too far. Often, this manifests itself in the over-use of personal protective equipment (PPE). I visited a service recently where staff were wearing aprons and vinyl gloves in assisting a client to eat. This only served to create a barrier between the person and the care worker. What's more, if it becomes ingrained in the culture, the home can feel like an institution, and not the person-centred service that CQC advocates.

Finally, many people ask for advice around the last KLOE, which centres on lessons learned. I always tell people that it's not making a mistake that matters, but whether a service is able to understand why it happened, and then put systems in place to ensure that it doesn't recur.

When errors are made, it's important to create an environment where staff feel able to raise an issue and don't suffer negative consequences from doing so. It's also essential that, if an incident occurs, providers realise their limitations and aren't afraid to call in outside help.

Ultimately, Outstanding care operators instil a culture of shared responsibility – particularly around quality assurance, and always undertake proper root-cause analysis so problems which are identified do not re-surface.

THE THREE C'S

At the beginning of this article, I echoed CQC's view that achieving an Outstanding rating in the Safe key question was virtually impossible. Trailblazing providers are showing, however, that the impossible is possible with the right mentality.

As a care professional, my primary driver has always been to improve the quality of social care

for the people who use services. Over 25 years, I've worked on the front lines – starting as a care assistant – and I understand the everyday challenges that care workers face. I've also been a registered manager, a policy writer and an inspector. My greatest passion is sharing my vision of how care providers can achieve the best possible CQC rating, using compliance as a central driver.

My advice for anyone wishing to improve their rating is to concentrate on the ideas that make for outstanding care, rather than focus on achieving an Outstanding rating. It is not a tick-box exercise and those that have their 'eyes on the prize' often end up disappointed.

In my experience, those who embrace the ideas in this article, which I summarise as the three 'C's – Collaboration, Co-production and Compassionate, person-centred care – are more likely to be rated Outstanding. Not only were they living and breathing the values, but in doing so, they were naturally fulfilling CQC's criteria. That's the real secret to achieving an Outstanding rating. **CMM**

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What can you do to improve your Safe rating? Have you made changes that have resulted in improvements already? Let us know on the CMM website, where you can also feed-back on this article, **www.caremanagementmatters.co.uk**

INTO PERSPECTIVE

WILL ROBOTS WORK IN ADULT SOCIAL CARE?

This month, our experts are looking at how robots will work in social care. What benefits do they bring? What are the downsides? What do we want them to be able to do, and, importantly, will they be able to do it?

Studies continue to pop up about the use of robotics in social care. Some look at the implications of robots from an ethical point of view, some look at how people in social care settings interact with robots and some examine the benefits and outcomes achieved. But what is available and what can these robots do?

HOW FAR HAVE ROBOTS COME?

Robots first came on to the social care scene in a big way when Pepper was launched in 2014. Pepper is a 4-foot-tall humanoid robot that has been designed with the ability to read emotions and interact with others. It has arms and a face, which contains two discreet cameras, and can hold conversations with people using its 'voice'. It also has a screen on its front which allows it to show videos and play games with people, and the robot can even send emails and store people's personality traits.

Pepper has been used worldwide for various tasks but in social care it is seen as a tool for companionship and entertainment. The idea is that care providers would own a Pepper, which could then interact with clients and make sure everyone is okay. It can also report to care staff if it picks up on cues that someone isn't okay or if someone has said something to it that could be a cause for concern.

There is currently little inclination from the sector for Pepper to be used to provide personal care, and it isn't able to support with paperwork, but the hope is that this robot will be able to alleviate some of the strain on care workers who can have more time for one-to-one interaction with residents, while Pepper keeps others entertained.

ROBOTS AS PETS

Robotic animals are another much-discussed technology that has appeared in recent years. These have been around for longer than humanoid robots, but offer similar options in terms of solutions.

The animals vary, from a baby seal to a sleeping cat, but all of them are covered in fur and sized to fit on a person's lap.

People are able to stroke the animals, and the robots will respond to human touch. For example, they might 'purr' when being stroked; some will also move to look like they are washing themselves.

Robot animals in social care are often seen as a tool for people with dementia, who sometimes find that it brings memories of old pets, and many people find that stroking and caring for the animal produces a calming effect for those who are experiencing stress or agitation.

FUTURE APPLICATIONS

The use of robots in social care is on the rise. Benefits could include better outcomes for people in care and more meaningful interactions with care staff.

But there is a risk that the wider use of robotics could cause some services to spend less time with residents, leaving the robots to do all of the emotional support. Are robots ready to take this on and should we rely on them in this way?

The best _____ for the job

Karolina Gerlich, Chief Executive and Founding Director, National Association of Care and Support Workers (NACAS)

Social care is at its best when focused on relationships. That is difficult to achieve in a sector that has been neglected by the government for decades. Currently, vacancies for care workers stand at over 110,000, meaning that care work is often rushed and task-focused. Societal perceptions of social care – that it is low-skilled and revolves around personal care – do not help; in the short-term, the industry is looking at other solutions of filling these gaps. The solution on people's lips? Robots.

So, what do robots do well? Consistent quality service, repetitive tasks, reliable precision – all delivered without complaint. Robots can be produced in large numbers, and tailored to perform a similar role in different locations, for different people. And, seemingly putting the nail in the coffin of the care worker, they request no rest, sick-leave, or holidays. However, the question isn't 'Should a robot do the job of a care worker?', but 'Which parts of a care worker's job should be done by a robot?'.

What do care workers do well? Human interactions, relationships, empathy, understanding, emotion and patience.

Care workers are great at helping fight loneliness, depression and feelings of isolation. We help people feel cared for, listened to, and human; for some people that is the most important need. On top of this, care workers are great at personalisation, understanding and adapting to individual needs. Really getting to know the person, through meaningful and deep interactions, and adapting the way we work and what we do to suit the person's needs, likes, dislikes and triggers.

Crucially, care workers are able to provide human touch, and by that I mean literal physical contact. When words cannot reassure or support, and understanding silence is not enough, it is a hug or holding a hand that can make the real difference.

For me, robots could be perfect companions for moving and handling tasks, medication administration, and supporting daily routines.

For a sustainable social care future, we cannot think that we have to choose between innovation and tradition, between robots and care workers. Only by integration of both, with the best of both, can we deliver the best care and the best support for people's wellbeing.

Could provide effective companionship

Claire Sutton, Digital Transformation Lead, National Care Forum

We're already well into 2020 and the world doesn't yet resemble what we were promised it might in terms of hoverboards, self-driving cars, and affordable space travel, but it is becoming ever more apparent that robots, and the science behind robotics is gaining traction in social care.

Over the past few years we've seen robots being used in hotels, and to deliver parcels to homes, but alongside these well publicised uses, 'robots' have also been used in care settings.

There's a growing number of care providers using 'robot animals', such as PARO the seal. PARO is designed to learn intonation of voice and recognise whether it is being praised, or greeted. It can also recognise how strongly it is being petted.

Pepper has also been used in a number of care environments. Essentially Pepper looks like the stereotypical humanoid robot we were promised would serve us in 2020; it can perceive emotions and is designed to maximally mimic human interaction.

Neither of these solutions actually provides any personal care – but both offer proven evidence of how they can effectively provide companionship.

Other studies I've seen are focused more on how robots can be used as tools to reach set, defined goals, rather than as companions. Robots that encourage a particular movement, for example, can aid rehabilitation and physiotherapy. Where robots have been used successfully in other sectors, they have been used to carry out repetitive, often time-consuming tasks – freeing up a skilled workforce to spend their time in a more effective way.

Animal companion robots can be great; not every care home can have a cat, or a dog, or a seal. But whilst they can respond to voice and touch, they can't offer real, true companionship.

I believe we need to be mindful of the fact that, in spite of some of the promoted benefits of using robots in a health and social care setting, we must never lose sight of the fact that if a person being cared for is expressing feelings of loneliness that could be alleviated with actual human interaction, we should always consider the underlying cause of that, and focus efforts not on using technology to tackle symptoms, but to tackle the causes. Humanoid robots who can recognise someone's emotion and respond accordingly? Or a human who can recognise emotion and respond accordingly? In my opinion, we're not there just yet.

NCF **RISING STARS**

Nicolas Kee Mew is Home Manager at Riverdale Court, Avante Care and Support

CAREER

I came to the UK to study accounting in 2006. I needed a part-time job to support myself and a friend recommended looking for work in the care sector, so I started in a housekeeping position in a care home. I found that I was really passionate about the work I was doing and stayed at the organisation for seven years.

I got promoted, working my way through care roles, before moving to another company to become a deputy manager. In 2015, I then went to Arthur House where I took on my first registered manager position. It became one of the first care homes to receive an Outstanding rating from the Care Quality Commission (CQC) and that's something I am still very proud of.

Looking for a new challenge, I moved to Avante Care and Support in 2018, where I became responsible for the home I manage now. It was rated Requires Improvement and I was keen to make changes before our next CQC inspection. I was delighted when, in November 2019, we achieved Good, with an Outstanding in Well-led.

I'm also currently studying for a Master's degree in dementia, which is a particular area of interest for me. I'm looking forward to completing this and having a really in-depth understanding of the subject and using this throughout my work and with my team.

ORGANISATION

Riverdale Court care home is an 80-bed residential care home in Welling. We care for older people and those living with dementia. Riverdale Court is a popular and well-supported home with a great reputation within the local community.

Alongside our full-time care provision, we run day care and respite services too. There are a number of clubs and classes for residents at Riverdale Court, including an intergenerational foreign language class, where a local children's French club comes into the care home and teaches the children at the same time as our residents.

We encourage them to maintain or regain as much independence as they can using modern technology to support people; our home has >

> a dedicated sensory room and a RemPod as well as robotic cats and dogs. I also bring my dog to work, which the residents love, and our handyman does the same. We try to create a homely environment so that our residents and guests feel comfortable and relaxed.

CURRENT ROLE

I've been in my role for over 18 months now. Becoming a registered manager wasn't necessarily what I had planned. I didn't do well in my A-Levels but what I love about the care sector is that it's not all about that. You need passion and drive, and I make sure that my staff understand that any of them could be a manager one day if they want to be. One of the best parts of my job is seeing my team recognised for their hard work and being promoted, and helping them to progress in their careers.

I like to show my staff that they have my full support. I started at the bottom rung of the ladder so I've seen and experienced a lot of things. No-one is perfect, things go wrong but it's how we react to these things that make us who we are.

I think that being enthusiastic about your work makes it more rewarding, and having appreciation shown by our community is so motivating. It is a challenge, but I think anyone can be a manager – you just need passion, patience and a desire to always be learning new things.

The time management is one of the most difficult parts. No day is the same, which is a challenge that I love – I always say you have to be a chameleon in this job. But it does mean that your schedule goes out of the window on most days. Of course, the residents always come first, so if you were planning to do some paperwork, but then a resident needs you, there's no question which one you prioritise.

NCF RISING STARS

I first heard about the NCF Rising Stars programme at an NCF conference in 2018. I met the previous Rising Stars there and asked them about it to find out how it all worked. I went straight back to my manager and asked if they could put me forward. She did and I was so pleased to be selected.

I think it's a great opportunity for new managers to learn new things – and you get to learn from leaders like Vic Rayner, Neil Eastwood and other sector influencers. It's a huge privilege and I'm sad it's nearly over.

I feel so lucky to have had the mentoring and the opportunity to meet other Rising Stars and to be able to learn from each other. It's a brilliant programme and makes you feel like your role isn't just to be a manager – it supports us to be better leaders too.

FUTURE CAREER

For the immediate future, I plan to finish my Master's degree and then settle down a bit maybe. Looking further ahead, I am keen to one day progress to regional director and ultimately to make a change in dementia care; it's always been a dream of mine to write a book on this subject. I want to be a part of the people and leaders changing the social care sector, especially the dementia area.

I'm also a big advocate for care workers and their rights, and am keen for it to be recognised and considered as a professional career. I'm actually in touch with National Association of Care and Support Workers about this as I know it's a key focus for them.

ADVICE

My advice is to just go for it. Always believe in yourself and make sure you ask for help when you need it. When you talk to people about becoming a registered manager, they are often put off by the idea, but there is so much support out there. Being part of membership organisations that exist to help you do your best and talking to other people in the sector helps you to feel like you're a part of something.

I am really lucky to have a great connection with my line manager too, and I think that's important – to have someone who is supportive and is willing to learn with you.

Share your passion, see where it takes you and remember it's not always about the money – find a company where you are supported, happy and comfortable and you'll reap rewards in other ways. **CMM**

"Share your passion, see where it takes you and remember it's not always about the money."

Now in its third year, the NCF Rising Stars Programme addresses the need to invest in and develop the skills of the next generation of leaders in social care, with registered managers from the NCF membership selected to take part each year. For more information, contact Helen Glasspool at National Care Forum. Email: **helen.glasspool@nationalcareforum.org.uk** Twitter: **@NCFCareForum**

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SAFEGUARDING AND REGULATION IN THE CHARITY SECTOR

DAC Beachcroft has recently reported on the challenges faced by charities in the social care sector in terms of safeguarding, the role the regulators play, and how they are working to deliver on a complex matrix of obligations. Here, Alistair Robertson, Partner and expert in Charity Law at DAC Beachcroft, shares the report's findings in more detail.

Charity sector health and social care providers are facing increasing demand for their services and are playing an ever more vital role in early intervention schemes, community care and the development of integrated services. Alongside these new responsibilities, they are also facing a higher level of scrutiny and more punitive measures from regulators.

The Care Quality Commission (CQC) estimates that charities and other third sector organisations are responsible for delivering around a fifth of care services in England and, according to its State of Care report 2017/18, more than three-quarters of NHS and independent community providers (including charities) are providing 'Good' care.

However, there are many challenges facing the sector, including funding cuts and high staff turnover, which impact safeguarding, training and leadership. And with charities providing care and support predicted to be increasingly relied upon, they will need to ensure their organisational procedures satisfy both CQC and the Charity Commission.

THE ROLE OF THE REGULATORS

Currently, charities must duplicate certain information they are required to provide to both regulators. This is a costly and time-consuming burden, and increases the risk of discrepancies in the information itself and the way in which the regulators deal with it.

Looking specifically at safeguarding, this means that charities must be able to demonstrate to both regulators that they have strong systems in place to ensure they can identify and act upon safeguarding issues and that they can (and do) collect and act on feedback from clients to ensure services are improved. This is not straightforward, as the two regulators currently do not define 'safeguarding incidents' in the same way – which means one incident may have two different definitions according to each regulator and therefore require a different response.

With this in mind, the leaders who took part in our report, including Chairs, Chief Executives and Directors of social care charities, are calling

for a more joined-up approach in this area from both CQC and the Charity Commission. One leader commented that, 'It would be good if the two bodies got to a point where they could say, "this is what we commonly see as an incident" rather than people doing one thing for one regulatory body and one for another.'

The Charity Commission and CQC directly respond to points raised in the report. The Commission states that in relevant cases it works closely with CQC to share information and resolve concerns, prioritising the needs of the case and the individuals involved.

CQC comments that safeguarding arrangements and alert thresholds are managed by local authority safeguarding teams, writing, 'Safeguarding teams typically provide or signpost training and development >

> opportunities for services in local areas. We are not currently involved in determining thresholds with the Charity Commission.'

The discrepancy between the two regulators' definitions of safeguarding incidents, means a difference in approach in provider's response is required. A more joined-up approach would mean less duplication in charities reporting on, and responding to, incidents.

CQC also notes that it is the 'commissioners and providers [that] need to be clear and distinct about "serious incidents", "serious safeguarding incidents" and "safeguarding" – which may not be one and the same.'

The Charity Commission does state in the report that, 'To formalise our way of working, we are in the process of preparing a memorandum of understanding (MOU) [with CQC], setting out the terms of our joint working.' But for now, it's status quo: trustees must report serious incidents in line with Charity Commission guidance, even if it has to be reported again to CQC – or multiple other regulators.

In future, the role of the regulator is likely to evolve in line with the different demands on the sector, and there is evidence that regulators are becoming more punitive, particularly with providers working with vulnerable groups, and even more so with those in the mental health and learning disability sectors. CQC is increasingly interested in assessing whether services, and the organisations providing them, are Well-led. Where it finds evidence of client-safety related offences, it has not shied away from sanctions – including fines and criminal convictions. And the Charity Commission wants to provide more evidence of the impact it is making, and is also taking an increasingly interventionist approach, evidenced by its recent successful court application for finding contempt of court against two former trustees who failed to comply with an order to supply evidence and documentation to the regulator.

SAFEGUARDING IN PRACTICE

Many charities are setting good standards when it comes to overcoming the regulatory challenges in safeguarding and are working to improve their practices.

CQC's assessment framework makes it clear that providers must introduce effective arrangements for managing safeguarding, complaints and feedback from clients, and how this will feed into their quality and risk assurance arrangements.

CQC says charities must demonstrate that their feedback systems enable the involvement of service users when considering lessons learned, and that they take part in 'iterative, co-produced improvement' of services.

The Charity Commission expects charities to deliver their charitable work, 'Not just through their activities, but through their behaviour too.' A spokesperson explains that, 'Managing complaints and concerns appropriately, reporting serious incidents and being honest when things go wrong is an intrinsic part of this approach.'

Leaders we spoke to felt that key to their ability to demonstrate effective safety and governance to the regulators was their own capacity to implement good safeguarding practices and create a culture that supports this. One noted that, 'It's about setting the tone right at the top of the organisation, working on the basis that there are leaders at every level, and clear policies and frameworks for people to work within.'

However, concerns were raised from some quarters that safeguarding training is not always viewed as a priority by boards, and can even be seen as a wasted investment due to high turnover of workers and short-term volunteers.

The leaders we spoke to also felt that seeking to prioritise a culture of honesty and openness was an essential part of improving safeguarding practices, and this included offering a range of feedback options for employees and volunteers. They noted that robust whistle-blowing procedures and an open culture of speaking out can generate insights for leaders, and all of the report's contributors believed a 'no blame' culture was key to putting safeguarding at the centre of their organisation.

They emphasised this point on culture when it came to organisations with multiple sites or remote locations. To ensure safety and good feedback from remote sites, their advice is to nurture and educate leaders at every level to avoid blame culture; one contributor commented that, 'Giving people the confidence to report because they know it won't mean "off with their heads"' is a critical part of safeguarding in these environments.'

Another participant noted that, 'Having lots of routes for feedback to the organisation, whether that be independent whistle-blowing lines, management oversight, listening to customers...or staff surveys [offers] rich sources of insight and smart leaders make sure that all insight is available to help them deliver.'

Ultimately, it is about giving everyone a role in the safeguarding of individuals. However, it is also vital that charities don't simply collate the insights and data they gather, but act on this to satisfy the regulators and validate the culture of safeguarding.

MEASURING IMPACT

As one leader put it, senior leaders should be alert to the danger that feedback collection should not just come down to an 'exercise in quotas' – it needs to be more meaningful than this. It is important that charities know how to use the data they collect from feedback to effectively measure impact. They can then successfully act upon these insights and improve safeguarding where necessary.

Strong data infrastructure can feel like a 'nice to have' for cash-strapped charities, but it is vital in limiting the risk of safeguarding failures by helping to create an informed, open and honest culture at every level of the organisation. Large and geographically-diverse organisations in particular can lose their grip on how their services are performing if they do not have really strong data-reporting systems. Skimping on this can be a real false economy as the reporting requirements for safeguarding differ for each regulator.

The leaders who took part in the report explained how they use their collected feedback to drive a safer culture, measuring both the good and the bad in their organisations. Looking at the whole picture helps them drive measurable improvements, and organised data around compliments and complaints demonstrates to regulators that the service has robust systems in place to identify and act on safeguarding issues.

Ultimately, combining evaluation reporting and safeguarding reporting into a single set of mechanisms can ensure an organisation has a real understanding of its activities.

Charities pride themselves on being more fleet of foot than other sectors, but more agile methodologies for developing new service lines and policy initiatives don't always include consideration of safeguarding.

It's not always instinctive to design-in safeguarding in the same way that you would if a project were built at a slower pace. Charities should think about how and when they build in safeguarding as soon as they start working with people.

This is a question of culture and a shared vision of 'safety first and impact first'. It will also be determined by the direction of the regulators, who demand that strong systems are in place to ensure the safeguarding of people, and proficient delivery of care. **CMM**

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What do you think the regulators can do in terms of joined-up working to create a better system for all? Share your thoughts and experiences on the CMM website, where you can also leave feedback on this article, **www.caremanagementmatters.co.uk**

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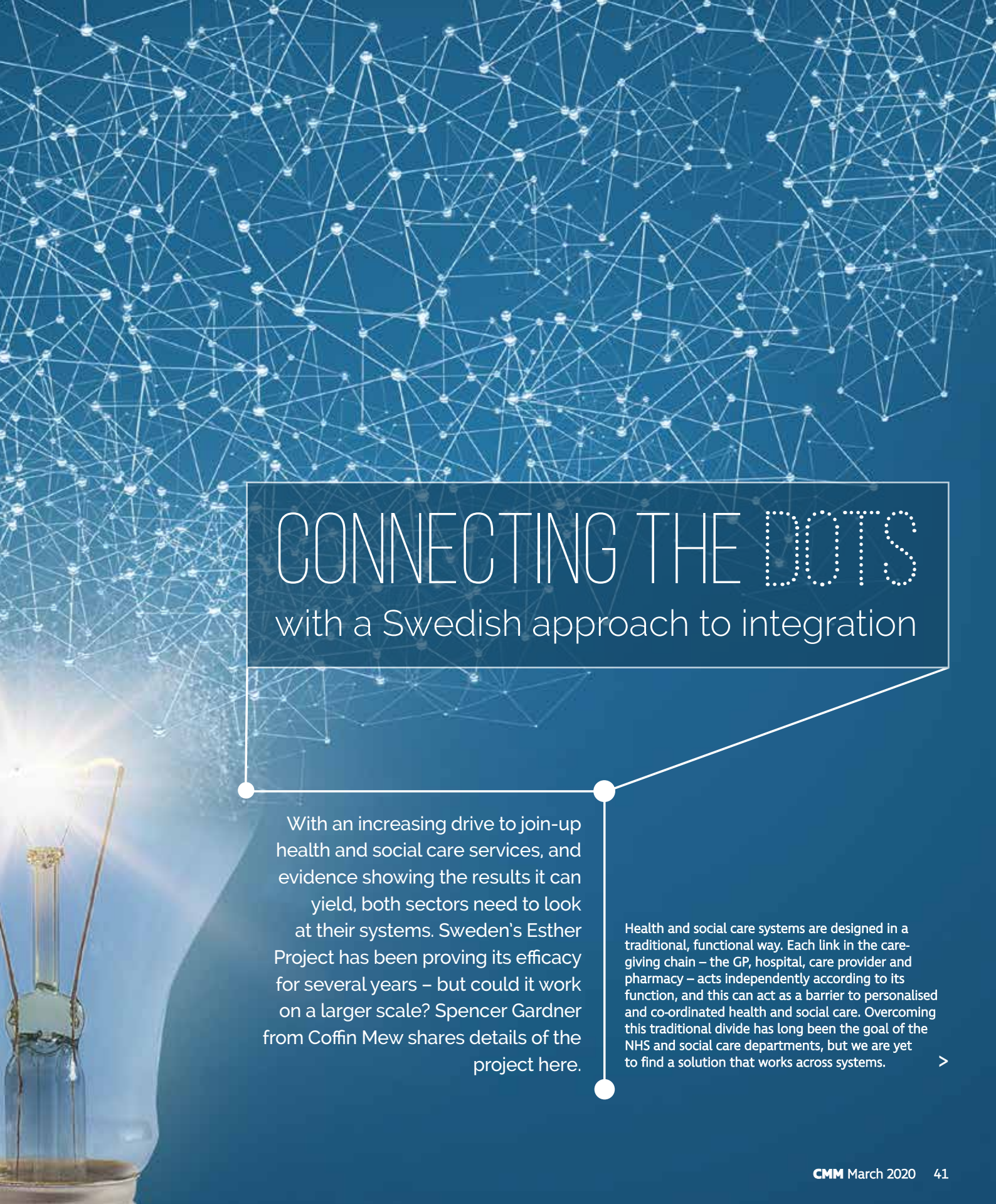

CONNECTING THE DOTS

with a Swedish approach to integration

With an increasing drive to join-up health and social care services, and evidence showing the results it can yield, both sectors need to look at their systems. Sweden's Esther Project has been proving its efficacy for several years – but could it work on a larger scale? Spencer Gardner from Coffin Mew shares details of the project here.

Health and social care systems are designed in a traditional, functional way. Each link in the care-giving chain – the GP, hospital, care provider and pharmacy – acts independently according to its function, and this can act as a barrier to personalised and co-ordinated health and social care. Overcoming this traditional divide has long been the goal of the NHS and social care departments, but we are yet to find a solution that works across systems. >

> Sweden's Esther Project is an inspiring example of how the power of a patient story can start to dissolve these boundaries and enable services to begin moving towards a more integrated, patient-centred system, ultimately, improving health and adult social care outcomes.

WHO IS ESTHER?

In 1997 in Sweden, Esther, aged 88 years old, developed breathing difficulties. She phoned her daughter in a nearby town, who told her to call her district nurse. The nurse visited and told her she needed to see her GP. Esther visited her GP, who told her she needed to go to the hospital, and an ambulance was called.

At accident and emergency, she was greeted by a nurse and waited for three hours to see a doctor, who examined her and sent her for an x-ray. She was admitted to a ward and treatment began.

During her five-and-a-half-hour journey through the system, Esther saw a total of 36 different professionals and had to re-explain her symptoms and history at every point.

Esther found herself lost in a system built around the provider, not the person. Limited value was created from Esther's interactions before and during her admission to hospital. The episode highlighted significant wastage in the system, which was due to the links in the care-giving chain not fitting smoothly together.

Furthermore, Esther's lack of knowledge of what to do and who to contact when faced with her health issues created a delay in her treatment and added to the workload of the nurses, which could have been prevented.

THE ESTHER PROJECT

Esther's experience gave inspiration to a team of physicians, nurses, and other providers who joined together to improve patient flow, integration and co-ordination of care for elderly patients in Höglandet, Sweden.

The team, led by Mats Bojestig, the then head of the medical department of Höglandet Hospital, initiated an extensive series of interviews and workshops between 1997 and 1999 to analyse people's care journeys in order to identify redundancies and gaps in the system, and to develop an action plan to reshape it.

During this time, Esther came to represent any older person who had needs requiring co-ordination between hospital, primary care and social care. Creating a persona in the form of 'Esther' helped health and care professionals to focus on the needs, preferences, hopes, and concerns of real people who needed care.

The series of interviews and workshops gave rise to a series of best practice questions professionals could ask themselves. Asking questions such as 'What's best for Esther?' and, 'What could we have done better for Esther?' at every stage of an older person's care, from their first interaction with them, helped Mats Bojestig's team focus on the needs, expectations, priorities and fears of people entering and moving through the system.

The team identified from their interviews and workshops that people felt healthcare personnel did not have enough time to listen, and that too many people were involved in their care.

The Esther model aims to combat these issues, using continuous quality improvement, cross-organisational communication, problem-solving, and staff training to provide the best care for older people with complex care needs.

"I think it is very important that we call this work Esther. It helps us focus on the patient and her needs. We can each imagine our own 'Esther.' And we can ask ourselves in our work, 'What's best for Esther?'"- Mats Bojestig, MD, Chief of the Department of Medicine at Höglandet Hospital, Sweden.

HOW IT WORKS

Traditionally, each provider in the care pathway – whether of health or care services – acts independently. 'But Esther needs it to all fit together,' states Bojestig. 'It needs to flow like an organised process,' he says, so each provider can take advantage of what others have already done or will do.

The result of a lack of co-ordination is that, while Esther's care or social worker knows all about how Esther lives, for example, 'Still her GP asks her how she lives, and she tells it, and the hospital asks her, and she tells it again, and so on.' Lack of co-ordination of information, particularly where medications are concerned, causes considerable redundancy and waste. In the worst cases, it can lead to medical errors.

The Esther Project, which Bojestig initiated, includes a set of goals for both 'Esther' and providers to improve the co-ordination between services and enable the best care for older people. These goals are:

Goals for Esther
- To get care in or close to home.
- To experience care from multiple providers as if it were from the same provider.
- To have care uniformly available throughout the region.
- To know to whom to turn when problems arise.

Goals for service providers
- All personnel to be committed to giving Esther's needs primacy.
- Commitment to mutual support to achieve the best for Esther.
- Increased competence through the care chain.
- Continuous quality improvement.

Because many of the problems experienced by Esthers usually involve more than one organisation, a central issue in creating the initiative was bringing together people from different levels and organisations. To achieve the aim of reducing fragmentation and improving co-ordination, the team developed multiple avenues allowing providers to come together and co-design a vision for a system that ensured Esther remained central to their work:
- A yearly steering group: A committee of >

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> community care chiefs of municipalities, hospitals, and primary care who discuss challenges seen across organisations.
- Quarterly Esther cafés: Cross-sector, multi-agency, client experience meetings held to share learning from the experiences of recently hospitalised patients who had continued on to homecare or other services.
- Ongoing training: Inter-organisational education sessions on palliative care, nutrition, fall prevention, and other topics to facilitate collaboration and understanding.
- An annual 'strategy day': Nurses, doctors, coaches, managers and Esthers coming together for team-building exercises, to identify priorities and generate ideas for addressing problems in the care chain.

Most importantly, each meeting involved at least one 'Esther' to guarantee that the clients' experience was always included.

DRIVING CHANGE

In 2006, the program began to train 'Esther coaches' across the participating organisations. Coaches were most commonly nurse assistants and nurses, but they also included physical and occupational therapists, social care workers, and administrators. Coaches were not paid extra – the work formed part of their jobs.

To become a coach, employees received eight days of structured training over eight months in problem analysis, quality improvement, and client focus. In their own organisations, coaches were expected to support improvement projects at the front-line, introduce ideas to improve competencies, make connections between daily work and performance improvement, inspire and motivate colleagues to improve, and introduce 'lean thinking' – that is, using the right resources in the right place at the right time to minimise waste, retain flexibility, and make workflows smoother.

"An Esther coach is a person with a deep and genuine interest to help fellow humans who are affected by the gaps in the health and social care system." – *Inge Werner, 2011*

INTERNATIONAL IMPACT

The Esther model proved inspirational. During the project, the team was able to achieve significant results across health and social care services.

Admissions to the medical department of Höglandet Hospital declined, from 9,300 in 1998 to 6,500 in 2013. Closer working between health and social care reduced lengths of hospital stay for surgery between 2009 and 2014 (from 3.6 to 3.0 days) and rehabilitation (from 19.2 to 9.2 days); and hospital readmissions within 30 days for patients aged 65 and older dropped from 17.4% in 2012 to 15.9% in 2014.

The reputation of this initiative has also crossed the Swedish border, with the model gaining international recognition for its success in making and sustaining large-scale improvements. Esther has spread across the globe – from Toronto to Singapore – with the approach becoming ever-more popular.

Esther also expanded to two systems in the UK in 2016. Now, in South Somerset, Esthers attend cafés every other quarter to report on progress they have seen. In Kent, cafés take place every two months, and around 1,400 care workers, social workers, chefs and administrators have been trained as Esther coaches.

A SHIFT IN CULTURE

The Five Year Forward View outlines a number of models of care that could help integrate health and social care, including a 'chains of care' approach to smooth the care transition. In recent years, investing in well-thought-out prevention campaigns has taken a backseat because of the immediate financial challenges facing both social care and the NHS. If we are to draw further inspiration from Sweden's long-term approach to public health and care, the lack of a long-term strategic framework for integration, which arises from a lack of investment, will need to be reviewed.

The Esther model is less about structural changes and more about ingraining a culture of quality-improvement with a seamless network of care around people who need the services. Consistent, clear communication between health and care organisations is crucial, as well as an understanding of the importance that each stage of the health and social care pathway can play.

Taking a system approach to meeting the needs of the elderly may seem odd at first glance. However, when viewed from the personal perspective of Esther, we begin to see how a more personalised approach can work. The Esther model depends on the power of people's stories. These stories, when elicited, give professionals vital insight into what is required to improve health and social care outcomes for all Esthers. **CMM**

Spencer Gardner is a Lawyer in the Care & Protection group at Coffin Mew. Email: **spencergardner@coffinmew.co.uk** Twitter: **@CM_SpencerG**

What are your thoughts on the Esther Project? Could it be a route to integration in the UK? How could it be explored here? Let us know what you think on the CMM website, where you can also feed-back on this article, **www.caremanagementmatters.co.uk**

CELEBRATING EXCELLENCE IN **END OF LIFE CARE**

Anne Robson Trust won the End of Life Care Award in the Markel 3rd Sector Care Awards 2019. Liz Pryor, Director, tells us about the charity.

When we started out on our mission to provide support to people dying in hospital back in 2017, we wouldn't have believed that within two years we would be on a stage at The Marriott Hotel in Grosvenor Square, accepting a national award from the fabulous Dame Esther Rantzen.

OUR STORY

My mother, Anne Robson, sadly died after a week spent in hospital in isolation. She was admitted in mid-January 2010, with a suspected fractured hip (otherwise a relatively healthy 79 year old), spent six days in a side room with no visitors allowed (it was thought, unfortunately wrongly, that she had norovirus), and discharged back to her care home a week later, in the words of her GP, 'a terminal, moribund patient'. Mum died a matter of hours later. Only two of my four siblings were able to be with her.

That was the starting point – when the seeds of the charity were sown. In the years that followed, I spent time working with different charities in and around hospitals, learning about the complexities of the NHS, and the challenges of looking after elderly people – some with families, some not. Many of these patients have multiple health issues and a frightening amount of them have some form of dementia.

When I was asked to look at improving end of life provision for a hospital where I was working, I soon realised that a massive difference can be made by providing 'more hands on deck'.

WHAT WE DO

Butterfly Volunteers – which Anne Robson Trust was created to expand – are people who work alongside nursing staff on wards, providing company and companionship to patients who have been identified as being in the last days and hours of their life. Many of these patients have no other visitors at all. Nurses want to have the time to sit with their dying patients, to hold their hand and stroke their brow – but realistically they just can't.

Since Autumn 2017, Anne Robson Trust has worked tirelessly to embed a team of Butterfly Volunteers at our pilot site, The Princess Alexandra Hospital in Harlow. It has an exceptional team of 30 Butterfly Volunteers who, since launching, have supported over 900 patients, and their loved ones, at this incredibly challenging time, providing an astounding 1,500 hours by the bedside.

The Princess Alexandra has recently become our Centre of Excellence for training Butterfly Volunteer Coordinators from other NHS Trusts, who go back to their Trusts after their training and begin setting up Butterfly Volunteer teams in hospitals in their area.

Butterfly Volunteers are specially-selected

and are trained over and above the NHS Trust's mandatory training (importantly, the Butterfly Volunteers work for the NHS Trust – they are not Anne Robson Trust volunteers). They are looked after by their dedicated Coordinator. We feel strongly that if the volunteers are properly looked after, made to feel part of a strong team, given exceptional training and one-to-one emotional support, they will provide excellent support to patients.

HOW DOES IT WORK?

Our model is a simple one. We work in partnership with acute NHS Trusts to help them quickly set up and embed teams of specially-trained volunteers to provide support to patients at the end of life.

To do this, we put a considerable amount of emphasis on recruiting the right person to the Butterfly Volunteer Coordinator post. If you get this right, the whole project runs smoothly from the outset. Get it wrong, and it will be incredibly difficult to make it a success.

We spend time with newly-recruited Coordinators – they visit our Centre of Excellence to undergo their induction training – they see the team in action, shadow volunteers, speak to families and patients (where appropriate), and begin to intrinsically understand what they are expected to do. Coordinators are trained to undertake the administration and data collection, using our tried and tested systems and documents.

They are supported to recruit their own team of volunteers, managing the whole process, from information sessions through to interviews, setting up their first training day, and getting their team out on the wards.

The Coordinators attend quarterly meetings with others from their area – so they also receive peer support and team spirit. They share best practice and come up with new ideas to tackle challenges.

LOOKING TO THE FUTURE

In 2019, Anne Robson Trust partnered with three more hospital trusts: The Norfolk and Norwich University NHS Foundation Trust; East Suffolk and North Essex Foundation Trust (with teams at both their Ipswich and Colchester Hospital sites); and the James Paget University Hospital in Great Yarmouth.

From small beginnings at Princess Alexandra Hospital in 2018, with just 20 Butterfly Volunteers, we've expanded to start the new year in 2020 with 106. We are also excited to have five new trusts in line to set up teams of Butterfly Volunteers in 2020, with more waiting to join. Our aim is to have national coverage in the next few years.

In the future, we are keen to look at providing support to residents in care homes who are approaching the end of their lives. There is so much emphasis on hospice care, and so many people volunteer in those environments – but we would like to see a move to supporting dying people in more settings; as other services come under increasing pressure, more and more of us will be facing the end of our lives in care homes.

The Markel 3rd Sector Care Award for End of Life Care has given Anne Robson Trust a national profile – and the confidence to speak out and expect to be listened to. We are the only charity in the UK working to embed volunteers in hospitals to support patients at the end of life. We are proud of the work that we do, and keen to expand our team so that we can make an impact far and wide.

We're grateful to the Markel 3rd Sector Care Awards and Care Management Matters for the support and recognition, and we are excited to see what 2020 brings.

It took lots of different twists and turns to get to where we are today – but we've done it, and I'm sure Mum would be proud of the charity we've created in her memory. **CMM**

Liz Pryor is Director of Anne Robson Trust.
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MARKEL 3RD SECTOR **CARE AWARDS** 3

The Markel 3rd Sector Care Awards is run specifically for the voluntary care and support sector. Visit **www.caremanagementmatters.co.uk/3rd-sector-care-awards** to see 2019's winners and find out more about this year's event. Sponsorship opportunities are available.

With thanks to our supporters: National Care Forum, Learning Disability England, The Care Provider Alliance, Association of Mental Health Providers and VODG.

The End of Life Care Award was sponsored by CareChoices

SKILLS FOR CARE ACCOLADES 2020

22nd January 2020, London

10 Skills for Care Accolades awards, celebrating excellence and innovation in workforce development across adult social care, were up for grabs at a gala event in London in January.

The Accolades, an annual event, are open to all 18,200 adult social care organisations and 75,000 individual employers in England who invest in learning and development opportunities for their workforces. All the finalists in the 10 categories won their place after coming through a rigorous verification process and an intense judging day with experts from across the sector.

CELEBRATING SUCCESS

Our sector isn't always the best at celebrating our successes, so the Accolades, which took place on 22nd January, has become an important event in the adult social care calendar to do just that.

Strictly Come Dancing star, Anton Du Beke once again played host and was quick to praise all the finalists for the outstanding work they do in their communities. He was visibly moved when the audience surprised him by waving paddles sporting '10's marking the first time in all his years on Strictly Come Dancing he'd won maximum marks.

STAND-OUT WINNERS

For the first time this year, the event was streamed on the Skills for Care Facebook page and proved very popular, with over 3,000 views.

Remote viewers were able to share in all the stand-out moments of the night, including when Community Integrated Care's Learning Disability Super League collected their award, prompting a victory dance that was worthy of an award in itself.

The full list of winners is:

- Best employer of between 51 and 249 staff – Community Support Services.
- Best employer of over 250 staff – Future directions CIC.
- Best employer of under 50 staff – Hendra Healthcare (Ludlow) Limited.
- Best employer support for your registered manager(s) – Leeds City Council, Adults and Health, Organisational and Workforce Development.
- Best individual who employs their own care and support staff – Richard's House.
- Most effective approach to continuing professional development for the regulated workforce in social care settings – Hertfordshire County Council, Adult Social Care, Adults Practice Development team.
- Most effective approach to leadership and management – Manor Community.
- Most effective collaborative approach to integrated new models of care – Community Integrated Care Learning Disability Super League.
- Most innovative endorsed learning provider – Springhill Hospice Education Team.
- Secrets of Success: Best retention and recruitment approaches – Lewisham Nexus Service.

LOOKING AHEAD

Planning is already well underway for the 2021 Accolades awards with entries opening in April. Employers from across the sector are urged to enter and get national recognition for the fantastic work their highly skilled teams do day in and day out to make sure the people they work with can live the lives they want to.

Quality Compliance Systems was the Accolades headline sponsor. Category sponsors were HC-One, Health Education England, Unique Training Solutions, National Institute for Health and Care Excellence (NICE) and Nursing and Midwifery Council. Media sponsors were National Care Association, Association of Mental Health Providers, Association for Real Change England, Associated Retirement Community Operators (ARCO), Think Local Act Personal (TLAP), Care England, Shared Lives Plus, National Care Forum, Voluntary Organisations Disability Group (VODG), Royal College of Occupational Therapists and Care Management Matters.

Find out more at www.skillsforcare.org.uk/accolades

WHAT'S ON?

Event: Future of Care
Date/Location: 3rd March, London
Contact: Broadway Events, Tel: 01425 838393

Event: Naidex
Date/Location: 17th-18th March, Birmingham
Contact: Naidex, Web: www.naidex.co.uk

CMM Media Partner

Event: Dementia, Care and Nursing Home Expo
Date/Location: 17th-18th March, Birmingham
Contact: Web: www.carehomeexpo.co.uk

CMM Media Partner

Event: Care Showcase Brighton 2020 - Inspire & Innovate
Date/Location: 25th March, Brighton
Contact: Care Showcase, Web: www.careshowcase.org.uk

Event: ADASS Spring Seminar 2020
Date/Location: 29th April – 1st May, Staffordshire
Contact: ADASS, Tel: 0207 072 7433

Event: LaingBuisson Social Care Conference
Date/Location: 13th May, London
Contact: LaingBuisson, Web: www.laingbuissonevents.com

Event: Digital Health and Care Congress
Date/Location: 20th-21st May, London
Contact: The King's Fund, Tel: 0207 307 2409

CMM EVENTS

Event: CMM Insight Northamptonshire Care Conference
Date/Location: 25th March, Northampton
Contact: Care Choices, Tel: 01223 207770

NEW FOR 2020

Event: The Transition Event
Date/Location: 30th April, Solihull
Contact: Care Choices, Tel: 01223 207770

Event: BAPS – SEND Blogging Awards
Date/Location: 21st May, Leicester
Contact: Care Choices, Tel: 01223 207770

Event: CMM Insight Leeds Care Conference
Date/Location: 11th June, Leeds
Contact: Care Choices, Tel: 01223 207770

Event: CMM Insight Lancashire Care Conference
Date/Location: 10th September, Blackburn
Contact: Care Choices, Tel: 01223 207770

Please mention CMM when booking your place.
Sign up online to receive discounts to CMM events.

COLIN ANGEL · POLICY DIRECTOR · **UNITED KINGDOM HOMECARE ASSOCIATION (UKHCA)**

STRAIGHT TALK

Colin Angel from UKHCA shares details of the revised Minimum Price for Homecare and why it's vital it gets paid.

Calculating the costs of homecare is an important event in my calendar at UKHCA. When Government announces new National Minimum Wage and National Living Wage rates, we get to work on spreadsheets and infographics to work out what this means for providers.

It is encouraging that our calculation is referenced more and more by local government and providers as the standard for measuring sustainable fee levels. It acts as a benchmark and its primary aim is to ensure that local government and NHS commissioners understand the minimum hourly rate that providers need to sustain their business.

From April 2020, we have established that the Minimum Price for Homecare is £20.69 per hour. This rate should not be confused with a 'fair price' for homecare – our calculations show only what it costs to pay staff and run the business whilst keeping it financially stable; the calculation does not include paying care workers above the National Living Wage, or include costs for rewarding the workforce. A 'fair price' would give providers enough money to help them retain their staff and recognise their essential contribution to society.

Our Minimum Price on the other hand, covers the minimum legally compliant pay rate for care workers (excluding enhancements for unsocial working hours), their travel time, mileage and wage-related on-costs. It also takes into account the minimum contribution towards the costs of running a business at a financially sustainable level, which must include the ability to make a profit.

Authorities and NHS commissioners who are perhaps looking for a way to pay less than the minimum price regularly say that costs of care in their area are influenced by local conditions. And yes, this is often true. But local conditions are far more likely to mean that the cost of care is higher in that area than our Minimum Price suggests. Our price is based on the legal minimum pay rate, and only being able to offer this rate to staff usually means that providers are unable to recruit or retain care workers from the local labour market.

The breakdown of the costs included in the £20.69 hourly rate is shown in figure 1. The assumptions which inform our calculations are regularly reviewed and each is backed up by published data and expert knowledge from providers.

This year, the National Living Wage will increase by 6.2%. This has had a big impact on our calculations, which have also seen a 1.3% increase in the costs of running a service – including regulation of provider organisations and/or the workforce in each UK nation.

Commissioners regularly underestimate providers' business costs, such as employing managers or supervisors, the actual cost of recruitment, fees that must be paid to regulators and other essential transactions. And while authorities are (rightly) intent on providers offering safe care that supports people's wellbeing, some are paying so little that, once the wage bill has been covered, there is not enough left to cover the running of the business. This is a dangerous approach. How can providers ensure a quality and safe service in these cases, let alone retain a stable and happy workforce?

I'd like to be able to say that all councils are taking on board the increases in National Living Wage and are offering providers an increase in fees to cover the costs, but this simply isn't the case. We are hearing from up and down the country that there are councils offering insufficient, if not zero, increases to their fees. Some have offered an additional 51p to cover the increase in National Living Wage, but this doesn't allow for other increased on-costs and providers will be left worse-off than last year. Our calculations suggest that an additional 94p per hour is needed as a minimum increase, just to allow providers to maintain their current financial position.

It's essential that councils understand and pay the costs of homecare. The state-funded market is already in a fragile state, and further pressures will only add to the ultimate possibility of wide-scale destabilisation.

Figure 1.

The main elements of the cost of homecare starting calculated for the statutory National Living Wage.

Careworkers' contact time	£8.72
Careworkers' travel time	£1.70
NI & pension contributions	£1.14
Other wage on-costs	£1.97
Mileage costs reimbursed	£1.36
Running the business	£5.20
Profit or surplus	£0.60
Minimum hourly price	**£20.69**

Colin Angel is Policy Director at United Kingdom Homecare Association (UKHCA). Email: **colin.angel@ukhca.co.uk**
Twitter: **@colintwangel**

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