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SOCIAL CARE INSIGHTS

From Simon Bottery



Reflecting on the importance of reliable data and how the pandemic has brought data to the forefront of the Government's thinking.

'Data' has to be one of the duller words in the English language. Unless you're a policy wonk, a business analyst or a scientist, you're not likely to get too excited when you see it in a sentence (and it'll score you just five points in Scrabble, so don't bother).

Yet it is now quite the hot topic in adult social care, an important marker of a change in attitude to adult social care by Government and – potentially – a route to increased influence. So bear with me.

Last month, the Government published its plans for integration of health and care in England and,

as a bonus, added a few additional measures specifically about social care. One of these was around data, where the Government is promising to 'remedy gaps in available data' in key areas such as hours of care services provided, cost per person and financial flows to providers and workforce.

This is quite the turnaround. There had been no shortage of laments to the lack of data before the pandemic arrived but no one in central Government was really listening.

So: why is data now such a hot ticket and should the social care sector welcome the focus or not?

Simply put, it matters now

because of the experience of COVID-19. Facing a crisis in care homes, the Government realised it had little information to understand the scale or nature of that crisis. Though urgent measures were put in place, by the autumn the taskforce set up to get social care through winter was still saying, 'One of the biggest challenges facing the country and the social care sector, while responding to its biggest public health crisis for more than 100 years, is the availability of timely and reliable data and information.'

The already-planned White Paper about the NHS and

integrated care offered an immediate opportunity to respond and the social care data provisions were piggybacked onto much broader measures about NHS leadership and integration.

The White Paper has no detail about the additional demands that might be put on providers and local authorities to capture it, though it does at least acknowledge concerns by promising that data will be 'collected through provider systems, reducing reporting burdens by extracting from existing data sets and sharing with multiple users'. However, assuming a suitable compromise can be reached, we should welcome the demand for two reasons.

Firstly, it is a recognition from Government that adult social care – particularly (but not limited to) care homes – is part of the health and care infrastructure of the country and has strategic, national value. That was certainly not the case pre-pandemic.

Secondly, as the White Paper says, with better, client-level data, it will be possible to make links to health outcomes, to understand the lifetime cost of care, join up care more effectively with health and plan for future population health needs. That in turn offers an opportunity to demonstrate the value of adult social care in terms that Government, and particularly the Treasury, understands.

And, if we have faith in the value that social care can bring, that has to be a good thing.

Simon Bottery is a Senior Fellow in Social Care at The King's Fund. Email: S.Bottery@kingsfund.org.uk Twitter: [@blimeysimon](https://twitter.com/blimeysimon)



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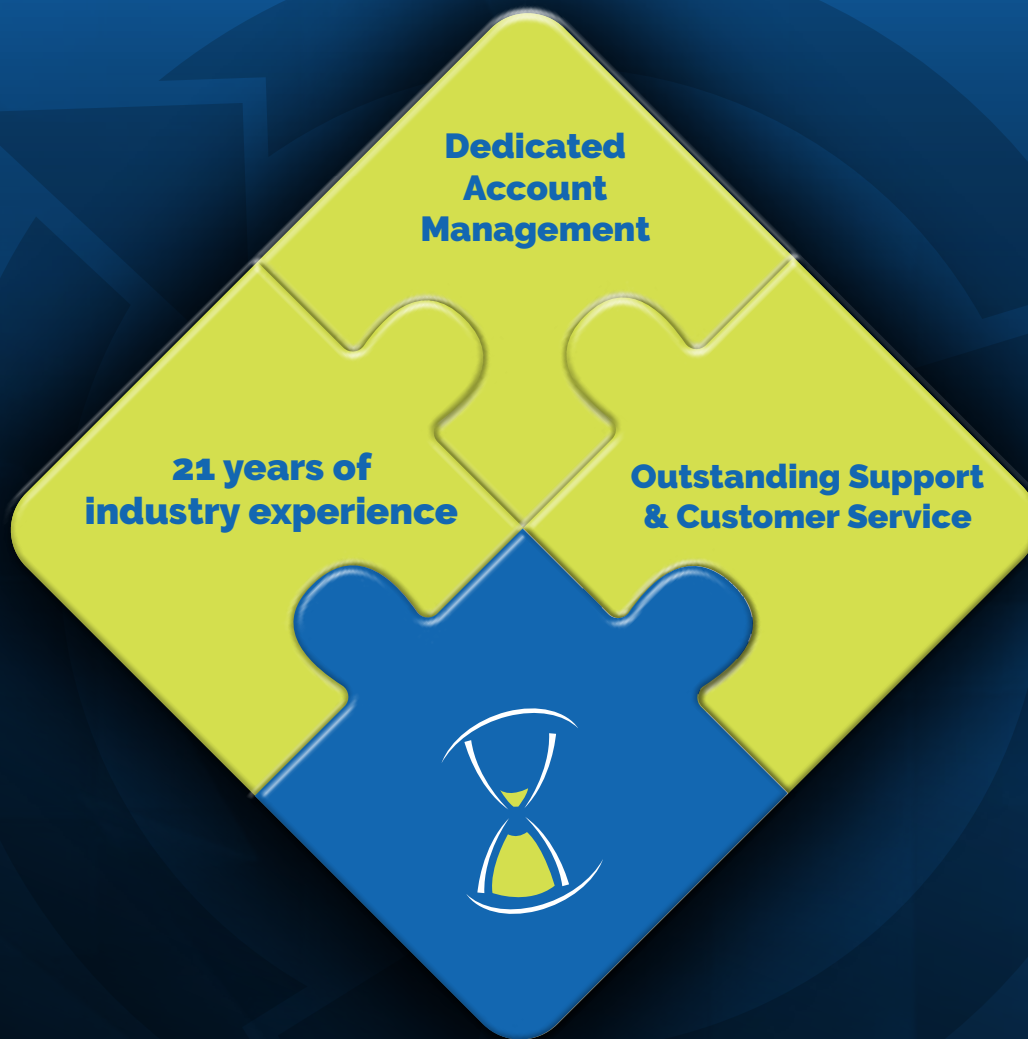
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Yvonne Shillock, Director - Embracing Care

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One Team, One Solution

The only thing constant in life is change. I'm sure like me, this is an expression you've been reminded of over the past year. Last month the Government published its *COVID-19 Response – Spring 2021*, setting out the roadmap out of the current lockdown for England. In this, there are further details on support for care home residents and staff, including updates to visiting guidance. Everyone will need to continue adapting and adjusting as circumstances change but I want to reassure you that we will support you through our regulated activity.

I know this year has had a huge impact on the mental health and wellbeing of colleagues. Marie Curie is holding a National Day of Reflection on 23rd March, the first anniversary of the first UK lockdown. This will be an emotional day, as we reflect on those we've lost, support those who have been bereaved and continue to do all that we can to keep people safe. If you feel you would benefit from some support with your mental health, The Care Workers' Charity has launched its Mental Health Support Fund which enables care and support workers to have 10 hours of counselling with a trained professional.

I've talked to you before about our campaign Because We All Care. We continue to work closely with Healthwatch to call for feedback from people. This month we're focusing on hearing from those with a learning disability and autistic people. Our research showed those with a learning disability and autistic people were more reluctant to give negative feedback on their care in case it increased pressures on services and staff. Please continue to encourage all service users to share feedback, good and bad. Last year just over 37,000 people shared their experiences of care with CQC through our Give Feedback on Care online form, a 29% increase on 2019. It's all making a difference, with 54% of risk-based inspections triggered by information from the public.

We're asking people to first raise concerns with the provider, but if they are unhappy about the matter not being resolved, then they should let us know. It's more important than ever that there is a culture of clear, open, transparent and regular communications between care providers and the families of their residents. We highlighted this in our recent news story on the importance of visiting. We're hearing from families who are

concerned that some providers are applying blanket visiting bans. In each of these instances we will follow up with the provider and take any action as appropriate. Where decisions are being made, whether that is for visiting, people not being allowed to see visiting professionals, testing or vaccinations, the focus must always be on the individual needs and rights of the person. If you're making a blanket decision, we're asking you to review these and talk to the people in your service, their relatives, loved ones and your local inspector.

We must all ensure that comprehensive advanced care plans and support is delivered in a person-centred way. This is highlighted in our final report on our review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 pandemic. This is an issue we have already spoken out about earlier in the course of the pandemic in a joint statement with the British Medical Association, Care Provider Alliance and Royal College of General Practitioners. The final report sets out our findings and recommendations. I'll talk about these recommendations more in future columns.

We paused the Adult Social Care Provider Information Return (PIR) for a year and in that

Inside CQC

K A T E T E R R O N I

Kate Terroni, Chief Inspector of Adult Social Care at the Care Quality Commission (CQC), updates on future reports and highlights the importance of regular communication with families.



time, we've been working on improving it. We piloted an updated version of the PIR in March. The PIR gathers important information not collected elsewhere which we use to support how we monitor the quality of care. We've listened to your concerns about provider burden and reduced the number of questions by a third across all areas. Alongside this, we continue to work with stakeholders across adult social care to develop our approaches to data collection and sharing. There is no link between the PIR request and our inspection schedules. We understand the challenges you're facing at the moment and in the first month we'll be testing our approach on a voluntary basis. We'll be sending requests to locations not reporting COVID-19 outbreaks, but if you can't make your submission – just let us know. We'll use your feedback in the first month to make further improvements before launching fully in April.

In my last column I highlighted our strategy consultation. Thank you to everyone who took the time to attend an event, submit a response or comment on a post. Designing and implementing a new way of working takes time and we want to get it right. We'll continue to engage with you as we begin to implement our strategy from May, so that we can make our strategy work for everyone.



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during these uncertain times.”*

Relative of resident at Hengist Field Care Centre

NEWS

Budget neglects social care, says sector

Leading social care organisations and charities expressed disappointment this month that adult social care did not receive due recognition in the Chancellor's Budget.

The National Care Forum (NCF) urged the Chancellor to quickly address the lack of acknowledgement and flagged that all ring-fenced emergency funding for COVID-19 will come to a halt on 31st March; however, it stated that none of the costs associated with providing care in a COVID-19 world would disappear and therefore urgent action is required to address short-term financial gaps in the Budget. The NCF has asked for the Government to outline a detailed

timescale for the full-scale reform of social care.

Executive Director of NCF, Vic Rayner, said, 'There is nothing in this Budget for social care. Nothing that acknowledges the massive financial challenges affecting social care provision. No recognition of the importance of investing in services that operate at a local level, employ local people and support the most vulnerable members of communities. Not even an acknowledgement of the incredible dedication and commitment of the social care workforce.'

Professor Martin Green OBE, Chief Executive of Care England, said, 'We are disappointed that social care, the real front line, hasn't

received the support that it needs so badly. This Budget still resembled an emergency one rather than one that provided any long-term assurance for the sector.'

The Relatives & Residents Association (R&RA) said the lack of detail on social care in the Budget was 'an insult to older people in care.' Helen Wildbore, Director of the R&RA, said, 'The sector was already on its knees before the pandemic hit and now it is at crisis point. Following a year of unrelenting challenges, with care services stretched to breaking point and staff burnt out, support from the Chancellor was desperately and urgently needed. Older people and their families deserve better.'

Updated guidance on care home visiting

The Department of Health and Social Care (DHSC) published new guidance relating to care home visiting.

The guidance came into effect on 8th March 2021 and replaced previous guidance. It applies to care homes for working age and for older adults.

The updated guidance includes the following advice:

- Every care home resident will be able to nominate a single named visitor who will be able to enter the care home for regular visits. These visitors should be tested using rapid lateral flow tests before every visit, must wear the appropriate personal protective equipment (PPE) and follow all other infection control measures

(which the care home will guide them on) during visits.

- Visitors and residents are advised to keep physical contact to a minimum. Visitors and residents may wish to hold hands but should bear in mind that any contact increases the risk of transmission. There should not be close physical contact such as hugging.
- Residents with the highest care needs will also be able to nominate an essential caregiver.

Care homes can continue to offer visits to other friends or family members with arrangements such as outdoor visiting, substantial screens, visiting pods, or behind windows.

Responding to the updated

guidance on visiting arrangements in care homes, Vic Rayner, Executive Director of the National Care Forum, said, 'The important introduction of the essential caregiver role will provide the vital continuity that our most vulnerable residents need. It will enable those residents who desperately need to be reconnected with loved ones to be reunited and have them once again a consistent part of their life in the care home.'

Helen Wildbore, Director of the Relatives & Residents Association, said, 'Asking care providers to enforce a single named visitor per resident is likely to lead to heart-breaking, difficult conversations at a time when care staff is already so stretched.'

APPOINTMENTS

RENOVO CARE GROUP

Renovo Care Group has appointed Health and Social Care Professional Peter Kinsey as its Chief Executive.

The independent specialist provider of assessment, treatment and rehabilitation for adults with neurological conditions, including acquired brain injury (ABI) and progressive neurological disorders, operates four services.

HEATHCOTES GROUP

Chesterfield-based care provider, Heathcotes Group, has appointed Emily Frost as Recruitment Business Partner to support its specialist residential services nationwide.

Emily brings experience in overseeing successful recruitment and talent acquisition within the health and social care sector.

LOVELL LATER LIVING

Paula Broadbent joins Lovell in April to take up the role of Managing Director of Lovell Later Living (LLL). Paula is formerly Retirement Solutions Director at ENGIE Places and Communities where she set up the LIFEstyle by ENGIE business.

Lovell Later Living recently joined the Lovell brand, integrating with the established partnerships business to work with their partners in addressing the growing housing crisis for the ageing demographic.

BURLINGTON CARE AND MARTON CARE HOMES

Burlington Care and Marton Care Homes announce Amanda Cunningham's appointment as Group Chief Executive Officer, following her successful stewardship whilst acting as Operations Director over Marton Care Homes since March 2020.

Government publishes White Paper proposals

The Government published White Paper proposals aimed to bring the health and care services closer together.

The measures include proposals to make integrated care the default, reduce legal bureaucracy and better support social care, public health and the NHS.

The Government said the reforms will enable the health and care sector to use technology in a modern way, establishing it as a better platform to support staff and patient care, for example,

by improving the quality and availability of data across the health and care sector to enable systems to plan for the future care of their communities.

The White Paper also named reform in updating the legal framework to enable person-centred models of hospital discharge and introduce improved powers for the Secretary of State to directly make payments to adult social care providers where required.

Responding to the Government

White Paper proposals, Vic Rayner, Executive Director, National Care Forum, said, 'What this Paper is not – is the reform of social care that we have been talking about and have been waiting for, for many years.'

'It is not the plan to 'fix social care' or the plan that is 'oven baked' and ready to go. The plan we are all waiting for, has once again been drop kicked over the date line – landing at some unknown point 'later in the year'.'

Social Care Institute for

Excellence (SCIE) Chief Executive Kathryn Smith said, 'We've been calling for social care reform before and during the pandemic.'

'Whilst this paper addresses many issues, there is still an urgent need for comprehensive reform. SCIE looks forward to working with the Department to deliver what those who draw on, or work in, social care desperately need.'

Visit the Government website for more information about the Government White Paper.

Providers race to protect mental health of workforce

Three in five providers dug deep into their own pockets during the last year to fund mental health first aiders as part of a raft of preventative measures taken to safeguard their staff, a newly published report reveals.

Independent research commissioned by learning disabilities charity, Hft, found that COVID-19 has taken its toll on the social care workforce, with 62% of providers reporting a rise in absenteeism relating to mental health since the beginning of the pandemic.

Compared to last year,

this marks a 10% increase on average across the sector, during a time when care staff are playing a crucial role on the front line to support vulnerable adults.

The report, reflecting on the previous year, highlights a rise in a range of actions that were taken to promote mental health across the board to protect the workforce, despite more than 56% of providers reporting declining surpluses or already being in deficit.

Nearly all providers (96%) reported signposting to mental

health services, up from 67%, while 87% provided mental health awareness training. The number providing in-house mental health first aiders has also risen from 38% to 62%.

The report also highlights that social care providers appear to be reaching a crisis point and have been forced to resort to measures to reduce capacity to tackle the persistent cost pressures over recent years.

Around a third (29%) of providers have made redundancies, in keeping with

the last two years, with one in 10 saying they have had to offer care to fewer individuals.

Dr Rhidian Hughes, Chief Executive of the Voluntary Organisations Disability Group, said, 'High-quality support services for disabled people can be transformative and this report, as we collectively look to recover from a truly challenging year, clearly exposes how the Government and its agencies must do away with short-term fixes and instead invest in sustainable, long-term reform.'

Poll reveals urgent need for reform

A major poll of politicians from across the political spectrum carried out by YouGov, on behalf of the Health for Care Coalition, reveals the pressing need for widespread social care reform.

The findings of a survey of nearly 100 MPs and over 500 English councillors, conducted between 25th November and 15th December 2020, highlight the pressing need for a long-term funding strategy and swift transformation in social care.

Nine out of 10 MPs said that local Government does not have enough resources to meet the growing need for social care

services and three in five believe that the social care budget should be raised by £7bn a year over the next two years.

Survey respondents demonstrate strong support for a long-term financial and workforce plan for the sector and for a funding settlement of an additional £7bn a year by 2023-2024, as recommended by the Health and Social Care Select Committee in October.

Other key findings were:

- Over three-quarters of MPs believe the budget for social care should be raised. This included almost two thirds who believed that it should

be increased by £7 billion a year and almost a quarter who believed the increase should be more than this.

- A third of Conservative MPs and nearly three-quarters of Conservative councillors believe the social care budget should be raised by £7bn or more to plug the funding gap.
- Three-quarters of Conservative councillors and almost half of all MPs think that social care should be funded by a new collective funding mechanism.
- 1.4 million older people are currently estimated to have an unmet need for social care, yet despite this, there have been

dramatic falls in spending on social care in England, with figures showing a 12% decrease per person over the decade to 2018/19.

The Health for Care Coalition said it is now imperative that the Government lays out a new plan for social care, which addresses the complex problems it faces including severe underfunding; an overstretched and under-valued workforce; a fragile provider sector; extensive unmet need; a lack of clarity about the cost of care; and a complex system to navigate.



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Charlie Mason,
Registered manager and director of Summerhayes Care Home



The Care Workers' Charity launches impact report

The Care Workers' Charity publishes its 2020 Impact Report, giving a comprehensive overview and insight into the work of the charity and its achievements.

The report shares the charity's journey over the past 12 months as the charity has gone from strength to strength in supporting social care workers during this turbulent time.

A few of the key achievements detailed in our report include:

- 2,864 COVID-19 Emergency Fund Grants awarded, with a total value of £1,981,858.
- 402 Crisis Grants awarded, with a total value of £285,37.
- 39 Funeral Grants awarded, with a total value of £64,945.
- The total value of all grants

awarded during 2020 was £2.2 million – an increase of 1,150% in grant-giving activities in 2020, compared to 2019.

Karolina Gerlich, Executive Director of The Care Workers' Charity, said, 'We're really pleased to share our journey over the past 12 months as the charity has gone from

strength to strength in supporting care workers during the turbulent year. We've seen many changes: a constantly changing landscape in the social care sector; new staff joining the charity; a wider awareness of the contribution made by social care workers and the development of vaccines to bring new hope to everyone.'

R&RA calls for CQC to monitor compliance

The Relatives & Residents Association (R&RA) is calling for the Care Quality Commission (CQC) to monitor care homes' compliance with new Government visiting guidance. This forms part of the charity's six-point plan on the change needed to end isolation in care. R&RA's six-point plan sets out the charity's desired changes to the visiting guidance, based on insights gathered from its helpline:

1. Essential caregivers to help protect residents' wellbeing.

2. Access to two designated visitors, in private.
3. Embed end of life as final year of life.
4. End blanket approaches to managing outbreaks.
5. Make sure it happens – CQC to monitor compliance.
6. Publish a strategy to end isolation for all.

The new guidance will give effect to the Prime Minister's promise to reopen care homes, as outlined

in his roadmap easing lockdown restrictions. With the guidance remaining advisory, rather than set out in law, it is vital that the regulator ensures compliance, says R&RA.

R&RA has been campaigning to End Isolation In Care since September. In a meeting with CQC's Chief Inspector of Adult Social Care, R&RA urged the regulator to be far more rigorous in helping to end the isolation, citing CQC's purpose to improve standards and protect

and safeguard vulnerable adults receiving care.

Helen Wildbore, Director of the Relatives & Residents Association, said, 'Following the Prime Minister's promise to older people in care that they will be reunited with their families, he must now ensure this becomes a reality. If the plan to reopen care homes is not to be made law, new guidance on visiting must build in a system to monitor compliance, to ensure change happens on the ground.'





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DHSC issues guidance on staff movement

The Department of Health and Social Care (DHSC) published guidance for care home providers on limiting staff movement between settings in all but exceptional circumstances to help reduce the spread of COVID-19 infection.

The guidance states that providers should not deploy staff to provide nursing care or personal care if those individuals are also providing a regulated activity in another setting. This is for both permanent and temporary staff, including agency and bank staff, staff who work across multiple sites

for the same employer and staff who work for more than one health and social care provider.

The DHSC said staffing requirements should be planned so routine movement is not necessary to maintain safe staffing levels and that mitigations, such as block booking, should be used to further minimise staff movement where an agency or other temporary staff are needed.

Should a provider need to deploy an individual who usually attends two settings, the new guidance says the provider should ensure

there is a 10-day interval between the individual attending the two settings and require a negative test result prior to the individual entering the home. DHSC said that this should be followed in 'all but exceptional circumstances.'

The DHSC has defined these exceptional circumstances by saying, 'These circumstances arise where a provider has planned its staffing requirements in accordance with CQC fundamental standards and is actively taking steps to address any ongoing resourcing needs but is still unable to ensure sufficient staff are

available to deliver care safely.'

The latest guidance states that all providers should complete the Capacity Tracker question 1.2 on staff movement, in accordance with the required reporting arrangements. 'Where providers have some staff movement under the exceptional circumstances described in this guidance, they should select the answer option, 'No – we have some staff working between services/settings, but we have exhausted all reasonable steps to ensure we have sufficient staff to provide a safe service'.

IHSCM partnership

The Institute of Health and Social Care Management (IHSCM) has partnered with Arden University, enabling members to access and influence relevant, career-ready courses and Arden students to enjoy the benefits of IHSCM membership.

The IHSCM will work with Arden

University to enable sector leaders from its member organisations to contribute to curriculum development and delivery, as well as enrolling all of Arden University's School of Healthcare Management students into the Institute. Arden's 1,000 healthcare management

students will enjoy unlimited access to the IHSCM's diverse range of events, conferences, workshops and networks as well as opportunities for mentoring and coaching.

IHSCM's CEO, Jon Wilks, said, 'This is a wonderful partnership in the full sense of the word, enabling

our members and Arden's students to enjoy learning and development opportunities together. We are delighted at the potential for further collaboration that it provides and believe that this is a great template for development of health and social care education.'

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Vaccine priority for people with learning disabilities

150,000 adults with learning disabilities will be prioritised to receive the COVID-19 vaccine.

This is not a change in the Joint Committee on Vaccination and Immunisation (JCVI) priority list but an operational clarification to ensure those with a severe and profound learning disability receive their offer as part of cohort six.

Professor Wei Shen Lim, COVID-19 Chair for JCVI, said, 'The JCVI's advice on COVID-19 vaccine prioritisation was developed with the aim of preventing as many deaths as possible. People who are severely affected by learning disabilities are at higher risk of death from COVID-19. As the severity of any disability may not be well recorded in GP systems, JCVI supports the NHS operational plan for anyone on the GP Learning Disability Register to be invited now for vaccination as part of priority group six, and to reach out in the community to identify others also severely.'

Dr Rhidian Hughes, chief

executive of Voluntary Organisations Disability Group (VODG), said, 'As soon as the news of the COVID-19 vaccination programme was launched, VODG and others called on the Government and its agencies to ensure disabled people were not left behind in the rollout of the programme and wrote to The JCVI advocating for people with learning disabilities to be re-prioritised.'

Sarah Battershall, Director of Quality and Practice Development at United Response, said, 'Prioritising as many as 150,000 adults with learning disabilities is the right path to take to protect a group of people confirmed by experts as being at much greater risk of this awful virus.'

There must, however, be continued efforts to vaccinate even more people with learning disabilities to ensure everyone in this group promptly receive their vaccine in the coming weeks. There are as many as 1.13 million adults with learning disabilities in the UK, so today's news must be seen as just the beginning.'

MPs to explore end of life housing

More than two-thirds of people say they would prefer to die at home and dying at home is often used as an indicator that someone has had a 'good death'. This inquiry, from the All-Party Parliamentary Group (APPG) for Terminal Illness, will explore the extent to which the experience of living in unsuitable housing, including the experience of fuel poverty, affects people living with terminal illness, their families and carers, and whether it impacts on someone's ability to die at home if that is their wish.

The APPG is seeking evidence from individuals and organisations with expertise in fuel poverty, housing and homelessness issues, as well as those who work with people experiencing poverty, health and social care providers

and people who have experienced terminal illness and bereavement.

The APPG's work follows its previous inquiry, which found that inadequate income can lead to considerable financial strain, stress, anxiety and health impacts on people at the end of life, and a report on fuel poverty by the end of life charity, Marie Curie, which concluded that the impact of fuel poverty can hasten the death of some people with a terminal illness.

The period of consultation will run until Friday 2nd April 2021.

All evidence and insight provided will support the APPG to give recommendations to Government, policymakers and providers to improve the end of life experience of people living with terminal illness.

IN FOCUS

Boosting later life housing: new report

WHAT'S THE STORY?

A report argues that if we are to successfully improve people's quality of life in later life, the Government must commit to finding ways to improve the quality and quantity of housing that facilitates care and support. The Social Care Institute for Excellence (SCIE) leads the commission, which is funded by the Dunhill Medical Trust.

The report provides an overview of the key issues facing the sector and outlines a vision for the future and some preliminary ideas which the Commission believes merit further exploration. It's a discussion document, setting out some questions and asking for people to contribute to the thinking of the Commission.

Anyone involved with housing and social care is encouraged to contribute their ideas.

Care homes, retirement communities, retirement housing, supported living and Shared Lives are the focus of the report.

WHAT ARE THE PROPOSALS?

The report sets out some initial policy proposals and actions for local areas to consider:

- An increase in capital spending is needed on new forms of housing that facilitates care and support.
- Better incentives are needed to encourage developers to increase levels of investment in appropriate housing.
- Reform in the planning system. For instance, retirement community housing is not currently defined within the planning

system, making it harder to build these as compared with care homes.

- A clear regulatory framework for retirement communities. There is a need now to implement sector-specific legislation on regulations and standards.
- Prevention needs to be at the heart of the strategy for improving the quality of housing that facilitates care and support. Initial proposals for further reforms include, for instance, a commitment to invest in housing that facilitates care and support.
- Improved information, advice and advocacy to support informed decision-making for people seeking housing that facilitates care and support.

WHAT WOULD THE IMPACT BE?

The Commission's Chair, Rt Hon Paul Burstow, who also chairs Social Care Institute for Excellence, said, 'The Government's health and care White Paper has a large housing shaped hole at its heart. The White Paper is all about integrating health and care – getting the right housing options can pay big dividends for people in later life when they have care and support needs.'

'Now is the time for a national strategy that invests in dramatically increasing the number and choice of places to live that provide access to personalised care. Above all we need a change in mindsets so that housing, care and support go hand-in-hand and are sustainable.'

Nursing applications up by over a third

Health and Care Ministers have welcomed the latest figures showing the number of applications to undergraduate nursing courses this year is a third higher than last year.

UCAS has received 48,830 applications to nursing courses in England, up from 35,960 at the same point last year, representing a 34% increase.

Last year, the number of people accepting a place on

a nursing course increased by 27% compared to 2019. Health Education England is working with health and education sector partners to make sure there are enough places for all suitable applicants who will go on to take up vital jobs in the NHS or social care sector. The figures for England also show:

- An increase in applications of more than 50% among 25- to 34-year-olds and 43% among

35-and-overs.

- 41% rise in male applicants.

Last year, the Government introduced a new training grant for eligible nursing, midwifery and allied health profession (including paramedic) students of at least £5,000 a year, which does not need to be paid back.

Nursing students will also benefit from additional financial support for childcare and for

those who study specialisms which typically have fewer applicants such as mental health or learning disability nursing. Eligibility for this is in line with existing criteria for tuition fee and maintenance support from the Student Loans Company.

Minister for Care, Helen Whately, said, 'We're another step closer to delivering 50,000 more nurses for our NHS and providing better healthcare for everyone.'

Council care cost criticised

The Local Government and Social Care Ombudsman is reminding councils that people can spend their money as they wish, within reason, when paying for their own care, after an investigation found faults with the way Cornwall Council assessed a man's finances.

The reminder has come following a complaint to the

Ombudsman that Cornwall Council made a number of errors when establishing how much the man needed to pay for his care.

According to reports, the council's calculations meant there was a delay in funding the man's care when his capital fell below the Government threshold of £23,250.

The Ombudsman is also

reminding councils that they must disregard half of a person's work pension when calculating how much they must contribute towards their care if that pension is being used to support a spouse or civil partner.

Michael King, Local Government and Social Care Ombudsman, said, 'I am issuing this report because I believe

there may be systemic problems in the way Cornwall Council assesses people in the county.

'I have asked the council to identify anyone else adversely affected by similar issues over the past 12 months and provide them with a remedy too.

'I am disappointed the council has not yet agreed to do this, so I urge it to reconsider its position.'

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Keele University develops musculoskeletal support tools

Keele University has contributed to the design of a suite of support tools to help people with back, shoulder, hip and knee pain, in partnership with Versus Arthritis.

A team from Primary Care Centre Versus Arthritis at Keele University has helped to create a range of decision-support tools to help people who are living with painful musculoskeletal conditions to make informed choices about their treatments.

The tools, which have been endorsed by the National Institute for Health and Care Excellence, are a set of questions and answers, which are used together with a

healthcare professional to support a conversation about treatment, whilst also considering the day-to-day lives of patients.

As part of the NHS England-funded project, the group summarised the current evidence and national guidance for treatment of each condition, as well as providing its expertise regarding the management of painful musculoskeletal conditions and shared decision making between healthcare professionals and their patients.

The tools were co-designed by an Expert Advisory Group, chaired by Versus Arthritis, which

included people with pain or arthritis, general practitioners, rheumatologists, physiotherapists, policymakers, academics and decision-support experts.

Dr Benjamin Ellis, Senior Clinical Policy Adviser at Versus Arthritis who led this project, said, 'Almost 19 million people in the UK live with the pain and disability of musculoskeletal conditions such as arthritis and back pain. Funded by NHS England, these decision-support tools will empower people with these conditions to work with their healthcare professionals to receive the support they want and need.'

Retirement village completion

The construction firm, Stepnell, has delivered a new exclusive £12 million care facility in the West Midlands. The scheme, located in Eastcote, Solihull was completed in just over 18 months on behalf of luxury care home provider Cinnamon Care Collection, which has been recognised as a top 20 recommended care home group for the past three years.

The luxury care and retirement living development, named Eastcote Park, is now ready to open its doors to residents next month, providing residential and respite care, as well as a dedicated community for those living with dementia.

Adrian Barnes, Regional Director at Stepnell, said, 'We are really proud to have delivered this fantastic, advanced care facility for one of our repeat clients and one of the most highly regarded care home providers in the country.'

Shared ownership extra care housing

People aged over 55 in Medway are being offered the chance to buy a brand new apartment at two new developments in the area. Atlas

Place and Rogallo Place, from Optivo, are designed specifically for the older resident with basic care and further optional care packages

available. Atlas Place, offering 24 two-bedroom apartments, is part of the 350-acre regeneration of Chatham Maritime.



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NHS Digital publishes local authority workforce figures

The report, *Personal Social Services: Staff of Social Services Departments, England 2020*, covers the 114,100 jobs in local authorities in adult social care services – accounting for approximately 6.9% of the total adult social care workforce in England.

The report outlines the following key findings:

Total number of jobs

- As of September 2020, there were 114,100 adult social services jobs in local authorities in England (held by 110,400 people), up 0.7%

or 800 jobs from 2019. Since reporting began in 2011 there has been a decrease of 28.4% or 45,300 local authority jobs, although in each of the last three years there has been an increase.

Jobs by job role group

- Nearly half of all local authority job roles (52,100 jobs or 45.7%) were in direct care-providing roles.
- The Professional Job Group, which includes social workers and occupational therapists, has remained relatively stable,

currently reporting 21,200 roles. This is the only job role group to have increased since 2011, also up 100 jobs between 2019 and 2020.

Hours worked

- In 2020, an estimated 3.5 million hours per week were worked by 110,400 adult social care staff within local authorities, up 55,000 hours per week since 2019.

Age of workforce

- The average age of adult social care staff in local authorities is 47.7. This is 4.0 years older when

compared to the latest available equivalent for the independent sector (Skills for Care, 2020) and 4.8 years older than the NHS workforce average age.

Sickness

- 6% of directly employed staff had zero sick days in the year. On average, the mean number of sickness days for staff in local authorities is 10.7 days, up 0.5 days since 2019.

Visit the NHS Digital website to read the report in full.

Study reviews treatment for osteoarthritis

According to a study, based on initial first results, first-line treatment of knee osteoarthritis is effectively delivered digitally without a need for traditional face-to-face physiotherapy visits.

The research, independently undertaken by the University of Nottingham and led by Prof Ana Valdes from the Nottingham NIHR Biomedical Research Centre, involved Joint Academy's clinical and evidence-based digital treatment for chronic joint pain and aimed to address a rapidly growing health concern.

The randomised trial study results revealed that UK patients receiving digital treatment reduced their pain by 41%, while the same

number of patients receiving usual care landed at 6%.

A total of 105 people, who were 45 years or older with a diagnosis of knee osteoarthritis, participated in the study. They were allocated at random to two groups where one was treated digitally and the other group self-managed their symptoms according to NICE guidelines. Patients in the digital treatment were connected with licensed physiotherapists via a smartphone application where they received education and daily exercises.

Patients in the other group continued their traditional self-management programme according to guidelines and visited their general practitioner

when needed. In addition to experiencing substantially less pain than the control group, the patients receiving digital treatment also reported that their physical function increased by 48% compared to traditional treatment, whereby physical function increased by 13%.

Sameer Akram Gohir, physiotherapist and researcher at the University of Nottingham, said, 'The results of the study really show how much can be gained by treating chronic knee pain digitally and this will reduce the burden on the NHS, especially when we are going through the COVID-19 pandemic where services are already stretched.'

Agincare celebrates 35 years

This year marks the 35th anniversary of independent care provider Agincare.

In 1994, Agincare was one of the very first care providers in the country to be awarded a local authority block contract for home care for older people and now has over 70 public sector contracts nationwide.

From a single care home in Weymouth, Agincare has grown to deliver high quality and affordable care nationwide, employing over 3,500 people.

Call for occupancy strategy in care homes

Care England has written to the Secretary of State for Health and Social Care, encouraging him to put in place a system of occupancy strategy in the care home sector to support its future sustainability.

The letter refers to the strategies enacted in Northern Ireland, Scotland and Wales and that these offer well-trodden examples where this can work in an effective manner.

Care England has also written to every Director of Adult Social Care in the country regarding fee rates and the need to work in partnership with providers to ensure the best means of recovery in conjunction with

quality care with those in need.

The majority of care providers' costs are fixed and cannot in the main be reduced despite dropping occupancy levels. This includes their heightened staffing costs. According to Care England, all these costs will therefore have to continue to be endured despite significant drops in income. The net effect is that the financial pressures caused by dropping occupancy levels will continue (along with increased costs) well into and beyond this forthcoming financial year.

Professor Martin Green OBE, Chief Executive of Care England,

said, 'Decreased occupancy rates in the adult social care sector have had an adverse impact upon adult social care provider sustainability. Decreased occupancy rates have, in turn, increased care costs per head. This is at a time when care providers have been confronted by an array of COVID-19 related costs. An occupancy strategy would be a very effective way of increasing the sustainability of the adult social care sector in the coming weeks and months. This is of fundamental importance given the role which adult social care has, and continues, to play in England's response to the COVID-19 pandemic.'

New Wigan development

Urban Village Capital will complete a purpose-built development in the care home sector in April 2022 – an £8.5m scheme in Wigan.

The Croft, which features 66 en-suite rooms, has been developed by Urban Village Care – a sister company to Urban Village Capital which is solely focused on building and expanding the provision of quality care home locations across the UK to meet an increasing demand.



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RURAL COMMUNITIES:

Reshaping the delivery of
health and social care



How disproportionate is social care provision in rural areas? Mark Lumsdon-Taylor of The Rural Policy Group explores some of the challenges faced by rural communities and why the group is campaigning for change.

It has long been acknowledged that there is a disparity in funding levels between urban and rural settings. Rural settings receive less funding per head, notwithstanding the additional costs involved in delivering care in rural areas.

There are many challenges involved in creating a health and social care model suited to sparse and elderly rural populations and the post-Brexit and post-COVID recovery is providing an opportunity to lobby Government for investment in rural areas as a means of stimulating the entire UK PLC economy. Systems-thinking and fair funding for rural settings will lead to rural regeneration, rural economic growth and support the Government's plans for a green recovery.

CAMPAIGNING FOR CHANGE

In February, The Rural Policy Group invited MPs and speakers to discuss what these disparities look like in more detail. MP Anne Marie Morris said, 'The first problem with developing a rural health and social care strategy is that the concept of 'rural' is not clearly defined. In this context, rural does not mean leafy Surrey villages. Rural applies to those parts of the British Isles which are remote and relatively isolated with poor infrastructure. There is not even a unified definition across Government departments, or even within them. The Housing Department is looking at rectifying that but only for its own Ministry.'

So, how do we rectify the lack of local provision in rural areas? MP Morris said the question itself raises the issue of measurement. Provision of health and social care is measured at too high a level – it needs to be more granular. So, we have problems with *definition* and *measurement*.

THE WIDENING GAP

The financial settlement that comes into play on 1st April 2021 sees rural areas receive £11 less per head in social funding and 16% less per head for new social care grants. Urban areas will receive 61% per head more than their rural counterparts. Rural residents pay on average £96 per head

more in council tax despite receiving 43% less than urban areas in Government-funded spending power. Rural residents will fund 69% of their local Government spending power through council tax compared with urban residents who fund 57%.

Due to a lack of Government funding, rural local authorities are much more reliant on income from council tax. Over the years, council tax in rural areas has increased to higher levels than urban areas, which has had a detrimental impact on rural communities. Despite paying more, rural residents receive fewer services and, on average, earn less than those in urban areas.

In addition, NHS allocations to Clinical Commissioning Groups (CCGs) in rural and urban areas receive similar funding per resident, which does not consider the older rural demographic. Health and care systems are not set up for rural care and hospitals that miss targets are often penalised with further reductions in funding creating a downward cycle.

A report conducted by Age UK calculated that by 2020/21, public spending for older people's social care would need to increase by a minimum of £1.65 billion to £9.99 billion in order to manage the impact of demographic and unit cost pressure alone. It also notes that local authorities face additional pressures on their care budgets arising from implementation of the Care Act, National Living Wage and the costs of new requirements for care services. The impacts on individual rural council budgets from the growing demand for funded social care are troubling.

INCREASING OLDER POPULATION

Rural areas have a higher proportion of older residents and rural communities are becoming increasingly older. The proportion of older people within the overall population is increasing faster in rural areas compared with urban areas, especially for those aged 85 or over whose care needs tend to be more complex. The Office of National Statistics estimates that by 2039 nearly half of all



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➤ households in rural areas will contain people aged 65 or over. Older residents place extra demand on NHS services due to chronic illness, disability and mortality.

The family care gap is growing as the number of older people in need of care is predicted to outstrip the number of family members able to provide it. Increases in female employment, smaller family sizes, increased geographical mobility and increasing complex needs leaves a large gap in the provision of elderly care from within the family.

INFRASTRUCTURE

The difficulties of providing home care are compounded by other factors such as obstacles in patients accessing health care services that are further away and harder to access by public transport. Rural residents face longer journeys to reach a GP surgery than their urban counterparts. Rural Services Network (RSN) figures show that local authorities in rural areas have less money available for buses, with urban councils spending five times that of rural councils on supported bus routes. From 2009-2019, funding for rural bus services has fallen 43% in real terms.

This has been illustrated in recent weeks with the rollout of the COVID vaccine; while there are vaccination sites in rural areas, many of those at the top of the list to be vaccinated did not have their own means of getting to them. As ever, the local community rallied around and a combination of community buses, cheap or free taxis and neighbours helping ensured people received their potentially life-saving jabs.

The lack of infrastructure including transport issues and poor connectivity leads to deprivation in rural areas. Patients struggle to get to hospitals and there is a lack of GP services. In Kent, rural areas are not terribly remote, but the public transport infrastructure means villages can be quite isolated in health terms as it is difficult to reach the bigger, more well-served hospitals without a car. Even with a car, the hospitals can be a long drive upwards of 30 minutes.

PROVIDER PROVISION

Care providers operating in rural areas face a variety of specific challenges related to demographics, service provision and costs. A lower population density makes economies of scale difficult, resulting in higher per unit costs

for service delivery. Local authorities are keen to realise cost savings comparable with urban communities, without considering unique geographical conditions.

Rural healthcare provision may benefit from more specialist-generalist practitioners as residents struggle to see multiple consultants and nurses. Improved training of medical and care workers would enable services to be delivered in tandem. There is a need to create new care pathways to address the shortfalls in training and rework the geriatrician role.

Recruitment of care staff remains a challenge for rural care homes. In areas with a smaller pool of potential local employees, low pay and zero hours contracts do not help to attract staff, especially with more attractive alternatives on offer from the hospitality and retail sectors. Before the COVID outbreak the care industry had over 120,000 vacancies.

CONNECTIVITY COMPLICATIONS

According to the Rural Services Network (RSN), significant sums of public expenditure have been invested to extend the reach of superfast broadband networks into less commercial areas. This included match funding from rural local authorities (a cost not borne by urban authorities). However, there remains a noticeable gap between levels of connectivity in rural and urban areas. In England's rural areas 11% of premises – households and businesses – are unable to access a broadband connection with a 10 Megabits per second (Mbps) download speed. Industry regulator, Ofcom, considers this a necessary speed for everyday online tasks.

In the most remote rural locations connection speeds can be significantly worse. A survey of its members by the National Farmers Union in 2017 concluded that half (50%) could not yet access a basic two Mbps connection. In view of local authorities heavily relying on the web to publish resources and to signpost to community groups, it's of great concern that vulnerable groups could not be accessing the social care information they need to support their health and quality of life.

ISOLATION IMPACT

Older people being geographically separated from their families and in some cases living in isolation can become extremely independent and hesitant to being assisted by care professionals.

Isolation in rural areas leads to higher levels

of mental health challenges such as suicide, for example Devon has one of the highest levels of suicide in the UK. The farming community is also particularly affected by mental health problems. Nearly half of all calls made to The Farming Community Network's support helpline (between July-October 2020) have related to mental health.

TECHNOLOGY TO COMBAT GAPS

The advent of digital communications has provided a variety of innovations in health and social care that can improve service delivery, patient outcomes and wellbeing.

Social distancing rules in care homes have prompted staff to think of more inventive ways for residents to keep in touch with loved ones. The use of iPads, laptops, Zoom calls and Facetime have enabled people to communicate throughout the pandemic.

An exciting development for social care comes in the form of robotics and engineering. Robots that can hold simple conversations with residents have been found to improve mental health and reduce feelings of loneliness. Researchers at the University of Bedfordshire conducted a trial both in the UK and Japan and found that older adults in care homes who interacted with the robots for up to 18 hours across two weeks had a significant improvement in mental health.

However, many of these technologies are reliant on good digital connectivity, leaving behind those in areas without reliable broadband.

LEVEL PLAYING FIELD

However, despite the emergence of new technologies, the impact of a global pandemic shines a light on the disparity of funding in rural areas. Fairer funding from Government is required to improve health and social care services for rural communities now and into the future.

Going forward we need to look at how we build resilience and sustainability into the system. How can we make sure we make the most of AI? How can we make the most of the volunteers? How can we do the most to make sure communities are self-reliant and resilient so when isolated locations are cut off entirely (e.g., by snow) they can continue to provide good care and support to residents? Ultimately, rural communities must be part of the levelling up agenda.

CMM

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Are you a provider in a rural community? What strategies and initiatives have you implemented to improve social care provision for the community? Share your feedback on the CMM website, www.caremanagementmatters.co.uk

Time to talk:

SUPPORTING RESILIENCE IN THE CARE WORKFORCE

The image features three hands holding large, light-brown cardboard speech bubbles against a teal background with wavy patterns. One hand on the right holds a bubble at the top right. Two hands at the bottom hold two overlapping bubbles in the center. The central bubble contains text.

Jeremy Bacon discusses
the impact care work has on
emotional wellbeing and the need
for increased choice and access to
mental health and wellbeing support
for care workers.

Amongst the many long-standing and previously hidden problems brought to light in the past 12 months, the pressures on care staff, thrust to the forefront of the fight against COVID-19, stand out as being particularly acute and requiring immediate and comprehensive responses. Recognition of the impact that care work has on emotional wellbeing creates a challenge to ensure that permission and opportunity is offered to those who need it, to access support that allows them to stay well and continue in their work.

MAKING THE CASE

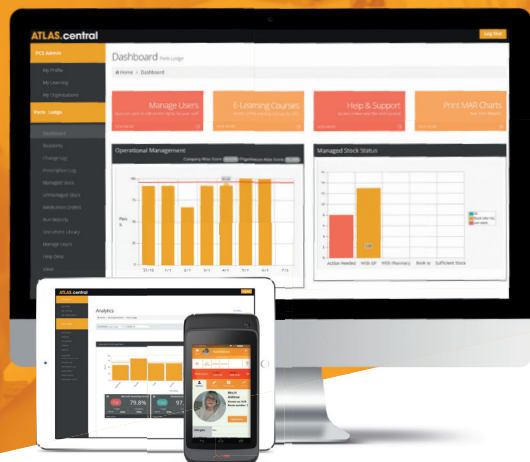
Last January, I wrote a short piece for *Care Management Matters* sharing information about the British Association for Counselling and Psychotherapy's (BACP) upcoming research into the feasibility of delivering counselling in care homes. In the early stages

of the project, care home managers urged the research team to include recognition and support of the emotional wellbeing of staff as well as residents. The case was well made that, by taking a whole-system approach to the study, additional insights could be gained into the value of talking therapies in care settings. A year on and whilst our care homes research has been interrupted and delayed by the pandemic, the call for recognition of the needs of staff from the care managers is in sharper focus than ever.

Evidence from the early stages of lockdown indicated significant worsening in self-reported mental wellbeing amongst care staff and increases in experiences of tiredness, insomnia, stress, anxiety, and depression¹. But of course, those with experience of working in the care sector know that, although not in public view, these emotional and mental health pressures were not new, but rather

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➤ were underlying conditions known to many care staff long before the pandemic. And being aware that such problems exist is only a starting point. How can people access the right support when barriers like time, cost and stigma all get in the way?

COUNSELLING CHANGES LIVES

The Office for National Statistics reported alarming figures on the rates of COVID-19 mortality amongst care staff, finding that once data had been adjusted for age and gender, social care workers were twice as likely to die from contact with the virus than the population average². For care staff from BAME backgrounds, this risk was found to be higher still and data on COVID-19 mortality in the UK has consistently aligned risk to socio-economic determinants of health³.

BACP is the professional body for over 54,000 counsellors and psychotherapists across the UK. Counselling changes lives and BACP believes that talking therapies, delivered by trained and qualified therapists, should be available to anyone who is struggling with difficult emotional circumstances leading to psychological distress. In response to the pandemic and lockdown there has been an increase in the delivery of therapy by telephone and video-conferencing platforms, and efforts to promote choice and autonomy for clients has remained at the forefront of the counselling profession.

For BACP member Susan Aston, there are particular barriers that prevent care staff from accessing the mental health and wellbeing help and support needed in times of crisis or when stress and worry are affecting their ability to get on with work and home life. These include the stigma of help-seeking, with many carers resolutely seeing themselves as 'givers' and often instinctively putting the needs of others before themselves. There's also the challenge of finding the time to dedicate to regular counselling sessions or being able to commit to regular weekly patterns for appointments, when the requirements of care work may include being available at short notice.

Susan has worked as a carer for a domiciliary care agency in the southwest of England and knows well the stresses that accompany care work. 'In the care giver role, the people we work with are always more than clients. We build friendships and trust that allow those who wish, to confide their innermost fears and concerns. We're the

people close enough to notice changes in their wellbeing and get the help they need. Many of our clients want to die at home; we look after them in those final weeks, days and hours. We're there when a syringe driver is administered, we hear when a dying person is calling out for their mum, we sit with them and hold their hand when there is nothing else to do except wait for death to arrive. Yes, carers have training on end of life care, yet when it is over, we move on to another client and so the cycle begins again. Even when someone decides they might need counselling help, the limited availability of free therapy and the prohibitive cost of paying for private sessions get in the way.'

SUPERVISION BRINGS A PERSONAL APPROACH

The recent announcement by The Care Workers Charity⁴ of a new scheme supporting care staff to access counselling support is a welcome and positive step. The offer has been made to any member of care staff across the UK to apply to the charity's Mental Health Support Programme, which can cover the cost of up to 10 sessions of counselling provided by trained and qualified therapists.

In her role as counsellor, working with clients who are care staff working for a domiciliary care agency, Susan Aston knows that the prospect of counselling can be daunting for many people and that it can be a difficult step to seek help. 'So many of the issues that people take to counselling, such as bereavement, loss and exposure to suffering, are part of the daily routine for many care staff. I've worked with counselling clients who have unresolved grief in their own lives that is brought to the surface every time a care client dies. Without the opportunity to address their personal loss and pain, their work carries an ever-present potential for great emotional distress.'

All qualified therapists commit to working to standards set out in the BACP *Ethical Framework for the Counselling Professions*, which states: 'Supervision is essential to how practitioners sustain good practice throughout their working life. Supervision provides practitioners with regular and ongoing opportunities to reflect in depth about all aspects of their practice in order to work as effectively, safely and ethically as possible. Supervision also sustains the personal resourcefulness required to undertake the work.'⁵

For Susan, reflecting on her work as a therapist in comparison to her care work, there exists a stark contrast in approaches to self-care. 'In counselling, supervision is one of the corner-stones of our profession, critical to ensuring safe practice and the wellbeing of counsellors, and, ultimately our clients,' she says. 'This is embedded as a compulsory part of our work when we undertake training – it's a 'must', not a choice.'

PUBLIC PERCEPTION

As poignant and pertinent as anything written since the outbreak of the COVID-19 pandemic last year, Vic Rayner's *'Ode to the Unseen Care Worker'*⁶ plots the meteoric rise in public perception and portrayals of care work, a journey that saw care staff move from 'low skilled' to 'incredible' in a few short weeks. But with this shift in status comes a challenge to back up the applause and plaudits with real change that recognises and rewards care work for the value it adds to communities and to society as a whole. An important part of this recognition should be an ongoing focus on the emotional wellbeing of care staff, acknowledgment of the personal toll of care work and increased choice and access to mental health and wellbeing support that cares for the carers.

CMM

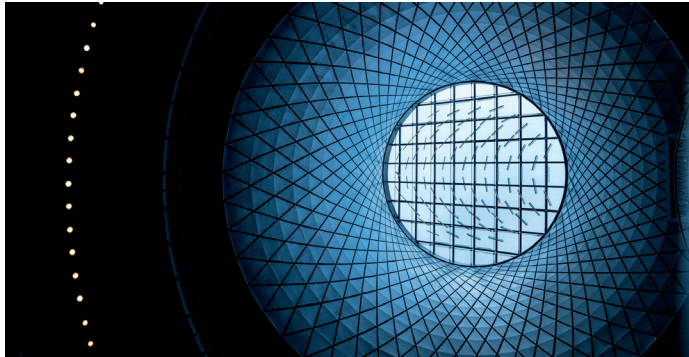
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WHAT DOES THE GOVERNMENT'S WHITE PAPER PROPOSALS ON INTEGRATED CARE PROMISE?



Intro commentary by Helen McKenna of The King's Fund

On 11th February 2021, the Department of Health and Social Care published the White Paper *Integration and innovation: working together to improve health and social care for all*, which sets out legislative proposals for a health and care Bill.

DUAL STRUCTURE

At the heart of the changes set out in this section is the proposal to establish integrated care systems (ICSs) as statutory bodies in all parts of England. ICSs will be made up of two parts – an 'ICS NHS body' and an 'ICS health and care partnership'. The dual structure is a new development and recognises the two forms of integration that are needed to adopt a population health approach aimed at improving the health and wellbeing of local populations: integration within the NHS (between different NHS organisations) and integration between the NHS and local Government (and wider partners).

The ICS health and care partnership will be responsible for developing a plan to address the system's health, public health and social care needs, which the ICS NHS body and local authorities will be required to 'have regard to' when making decisions. The membership of the partnership and its functions will not be set out in legislation – instead, local areas will be given the flexibility to appoint members (likely to be from the wider system – for example, Healthwatch, voluntary and independent sector providers, and social care providers).

The document also recognises the importance of 'place', which is a smaller footprint than that of an ICS, often that of a local authority. Experience suggests that much of the heavy lifting of integration and improving population health is driven by organisations collaborating at this level and successful ICSs have therefore often concentrated their efforts on developing the places within their footprint. The Department states that it has decided against giving place a statutory underpinning although

it is explicit that there will be an expectation that ICS NHS bodies delegate 'significantly' to place level as well as to provider collaboratives. The development of place-based partnerships will therefore be left to local determination, building on existing arrangements where these work well. ICSs will be expected to work closely with health and wellbeing boards and required to 'have regard to' the joint strategic needs assessments and joint health and wellbeing strategies produced by health and wellbeing boards.

Visit: www.kingsfund.org.uk/publications/health-social-care-white-paper-explained to read Helen's full commentary.

WHAT ELSE WAS PROMISED?

The Government said a new power for the Secretary of State to make payments directly to adult social care providers will remove a bureaucratic barrier to delivering support to the sector in exceptional circumstances. The DHSC also said it wants to increase accountability in the delivery of social care through an enhanced assurance framework examining the performance of local authorities and a new power to collect data from providers.

DATA INTEGRATION

The White Paper outlines that the Government aims to build on improvements made by existing tools such as the capacity tracker mandated during the pandemic and an increased ability to gather data from social care providers (for both local authority and privately funded care) and that they will remedy gaps in available data to help the Government understand capacity and risk in the system.



Define the role of care providers

Kathy Roberts, Chair of the Care Provider Alliance

We believe consistent approaches within an extensive and varied marketplace of providers across the newly formed 29 integrated care systems need to be developed.

ICS formations will have the potential to create culture change, but these culture changes never happen without all the partners being involved in co-design. This is something which has been missing in the proposal.

As well as partner organisations, it is imperative the social care workforce is placed on the same footing as its NHS colleagues. Furthermore, it is vital the voluntary sector and those who make frequent use of health and care and those who are frequently excluded from equal access to services are also included.

Our recommendation would therefore be genuine co-production with all stakeholders to define the role of the care providers within the ICS and Accountable Care Organisation (ACO) structures.

These would include yet not be limited to:

1. Clarity of knowledge around the commissioning and

2. Providing essential workforce support to the 1.6m social care colleagues with trusted partners such as Skills for Care.
3. Developing the ICS shared agenda for system improvement, enabling people accessing care to have choice and outcomes to live their best lives. Enabling improved wellbeing from social care services as well as better health outcomes.
4. Finding a path through the centre of national and local decision making with expert-led negotiation.
5. Considering the practicalities of how key performance indicators will work within the varied health economies for the ICS and ACO structures.
6. Sharing the best practice stories that inspire the process and online shared learning spaces.
7. Developing and recreating quality-led services that will drive innovation in practice.



We need to foster a culture change

Cllr David Fothergill, Health and Social Care Spokesperson for the County Councils Network

The Government's recently published Health and Care White Paper heralded an aspiration for closer integration between health and social care.

This, of course, was one of the aims of the 2012 reforms so it feels like we have been here before and, in practice many areas including here in Somerset have undertaken closer working between councils and the wider health ecosystem. But further enablers are welcome and an aim to create a system of localised health and care that is as seamless as possible should certainly be lauded.

So far so good, then: with the White Paper laying out a positive direction of travel. Proposals to align Integrated Care Systems with upper-tier local authority boundaries will hugely assist in the integration of health and care closer to communities – and this was something the County Councils Network (CCN) had been arguing for.

However, answering the question on what closer integration, as per the White Paper, looks like in practice is difficult with two major agendas still up in the air.

The first is whether social

care and the health service truly achieve parity of esteem. Many were disappointed that the long-trailed proposals for social care this Government has promised have still yet to see the light of day, despite health reforms being published. It is imperative that the care Green Paper is released as soon as possible so both sets of reforms can be implemented in tandem.

Secondly, social care must remain locally delivered by councils. This was emphatically argued in a recent report by care specialists Newton Europe for the CCN.

They set out an inspiring blueprint for reformed care locally – with local health, care providers, and councils all stepping up to work more closely and effectively: putting the individual first.

We can't simply magic up closer integration. We need the resources to drive reform, but we also need to foster a culture change with practitioners, providers and councils working more collaboratively.

Closer integration is what we are all aspiring towards – let's keep care local and build on the solid foundations we have in place rather than ripping them up.

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RETIREMENT REFLECTIONS

Erica Lockhart, CEO of the Surrey Care Association, has retired, following 48 years in the care industry. Her career included winning the 'Outstanding Contribution to Social Care' award in 2011. Here, she reflects on her career.



A CHANGE OF FORMATION

My career in care has been diverse, varied and tremendously rewarding. It started out in Newcastle in the early 1970s. This was soon after the release of *The Seebohm Report*, which set out key reforms for the sector, including the amalgamation of a number of functions to form a single social services department.

Even almost 50 years later, my memories of the consolidation of all the services to form Social Services are still vivid in my mind. As the services came together, it became apparent that so many parts of the system were all visiting the same family, all of whom had been previously visited by different departments. The formation of Social Services meant one social worker supporting one family. One particularly stark memory saw me involved in an eviction for the first time and we had to place the mother and children in a homeless hostel. It was like the harrowing, ground-breaking Ken Loach film *Cathy Come Home* in real life and it's an experience that has stayed with me and helped motivate me over the years to improve our services for the better.

It's fair to say I joined at a time of great – and much needed – change for the care sector and it's something I've witnessed



> first-hand over the course of my career.

PERSON-CENTRED APPROACH

One such instance of major change has been around the language used in care. For example, ESN (the educationally subnormal) was a widely used term which has rightly been reformed to people with learning difficulties, while those with disabilities were once called 'the handicapped' but, again, no longer. How we refer to people in care is crucial to projecting a positive image of the sector and language is now properly prioritised.

The quality of accommodation is another significant improvement in care. You used to see confused older people housed in dormitories or multi-bedded rooms with shared facilities – whereas now they will be in single rooms with en-suites, as we now correctly recognise and understand the needs of people living with dementia.

Many of these changes are reflective of a large-scale shift towards a person-centred approach. More often today, the person is at the heart of what we provide and that is a marvellous improvement.

Of course, for me on a personal level, a major development during my career was the formation of the Surrey Care Association. When no such association existed 15 years ago, care providers in Surrey were a disparate bunch, who operated independently with little by way of collective thinking or targeted aims.

AN EVOLVING PICTURE

The Surrey Care Association (SCA) came together out of necessity. With ever-changing regulations and an evolving care landscape, providers needed support in assessing and implementing these changes. The SCA was formed to develop a collaborative approach, helping those working in care in

Surrey to steer towards shared goals that benefited everyone.

Initially, the association was predominantly funded by the local authority and TOPPS (now Skills for Care) and the Learning and Skills Council. As a result of that funding, we were able to set up workforce training for the sector. It was considered a best-value initiative and the SCA was instrumental in researching what training was needed, commissioning it and monitoring its delivery. When the funding from Surrey County Council was reduced, the SCA continued to run training programmes for managers and owners very successfully; for example, we took the lead in helping providers to understand GDPR and its impact on their operations, as well as the Mental Capacity Act. We were the 'go to' place for training delivery, with many providers regarding us as the first port of call whenever they needed training or simply a better understanding of something that was set to affect their provision of care.

In a brave move that I'm proud of, we switched five years ago to a membership-funded organisation. Since that change, providers have now been represented independently and relationships with the key stakeholders have changed to a more meaningful dialogue.

The changes in sector regulation have required a significant amount of learning, with the ratings schedule proving very challenging for providers. The SCA was able to train care providers in the key areas so that they could make plans in their business and train staff and we continually evolved our training to meet these requirements.

NATIONAL IMPACT

It wasn't just in Surrey, though, where care associations were having an impact. Across the country, more and more associations were forming to

service regional needs. The aim was to create a unified voice. The SCA set up the Care Association Alliance (CAA) in partnership with the West Midlands Care Association. This looked to bring together local associations from across England, with a view to supporting SME providers, giving them national representation and helping ensure their needs and concerns are heard.

I am still co-chair of the CAA alongside Melanie Weatherley and it's gone from strength to strength. We conducted weekly meetings during the pandemic to project best practice and intelligence, while fostering a better understanding of how different local authorities operate – something that has been key in adding value to the alliance.

SUCCESSFUL SUCCESSOR

For my successor, the ongoing development of our sector is set to be a priority in the coming years as we emerge from the pandemic. The new CEO will need to focus heavily on this, supported by the Surrey Care Association's board of directors, who are already looking ahead.

In recent months, the board has done significant thinking on how to reinvent social care to reflect the current landscape, producing a detailed White Paper as to how they see it working, which includes the development of integrated health and social care – something that's set to be a challenging agenda. A real positive of the pandemic, though, has seen it bring SCA and NHS colleagues much closer together. For instance, we now do a weekly newsletter with contributions from our health sector colleagues. I hope our partnership work in this area will be strongly built upon, as there is much more to be done around the emerging Primary Care Networks and how the SCA and our members can support their services – we need to ensure our large self-

funded population isn't overlooked and ensure our significant number of services for people with a learning disability stays at the forefront of our thinking.

Another ongoing aim will be to properly convey the scale of our contribution during the coronavirus crisis, by continuing to reach out to non-members to offer our support and encourage those Surrey providers who have not yet done so to join our vibrant social care community.

A key area that will continue to be a focus for the association, and indeed the whole industry, is that of recruitment and retention. The care sector has long suffered from recruitment issues, but this has been exacerbated by the pandemic. And while a sometimes positive spotlight has been shone on our sector, which has helped encourage people to explore care as an option, we still need to see more people joining the workforce with the right values and compassion.

Like everyone nationally, we need to continue to raise the profile of social care, building on the positives of the pandemic to take the next step and secure adequate funding, which in turn should help attract the right staff. It's not just attracting staff though; we will need to focus on our existing staff to try and soothe the stresses of the pandemic by rebuilding their strength and wellbeing. Managers in particular have had an incredibly challenging role, and the pandemic has tested their leadership and resilience to the core.

Overall, I'm extremely hopeful for the future of social care. Reflecting on the span of my career, the improvement in that time has been profound and far reaching and I anticipate this evolution and positive development to not just continue but to gather pace in the years ahead. I look forward to observing with great interest in my retirement. **CMM**

Erica Lockhart is former CEO of the Surrey Care Association, an organisation that she helped to found more than 15 years ago.

Email: ericalockhart.consultancy@gmail.com Twitter: @SurreyCare

What changes and improvements have you seen happen during your time working in the social care industry? Share your reflections and opinions at www.caremanagementmatters.co.uk



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BUILDING PUBLIC SUPPORT:

#socialcarefuture



#socialcarefuture is a growing movement. Co-convenor of #socialcarefuture Neil Crowther shares findings and recommendations of new research into how to build public support to transform social care.

We have all endured restrictions and loss over the past year, reminding us of the value we place upon being in control of our lives, doing things that matter to us and being with the people we care about. The horizon of our lives and the choices we have been able to make have been extremely limited by events beyond our control.

CHANGING THE SOCIAL CARE STORY

The restrictions imposed upon those of us living in care homes have kept loved ones apart for months, some never to spend time with one another ever again. Given the evidence of the risks faced by those living in congregate care, we might see such measures as necessary. And yet, isolated and absent from the routines, interests, places and familiar people from which all of us draw meaning and purpose, the wellbeing of many people who are literally imprisoned in such settings has been seriously harmed. Even if they were fortunate not to get COVID, COVID still got them. Meanwhile, members of the #socialcarefuture movement who draw on social care to live in their own homes have commented that the support they received prior to the pandemic was already often so threadbare and restrictive that the lockdowns have not felt all that different from their everyday existence.

Without a significant shift, the future currently being anticipated for people who have reason to draw on social care is akin to a permanent lockdown and all the damage that will cause.

With all this in mind, one would hope that we would never now regard 'a good approach' to social care as one that simply aims to keep people alive. 'And yet, that is still how social care is overwhelmingly talked and thought about in general by the public, the media and political think tanks: as washing, feeding and dressing 'vulnerable people who cannot look after themselves.' Even when we read, listen or talk about 'fixing social care', all that is usually meant is funding more of the same old institutional or 'life and limb' care.

This is the dead hand of an unsupportive narrative in action. The public >

> story of social care is an obstruction to building the future that all of us really wants for each other. That's why #socialcarefuture set out to understand how it could be changed and we're extremely pleased to be able to report that it can.

SHIFTING MINDSETS

Following exposure to a new narrative, developed in partnership with strategic communications experts Equally Ours and public opinion researchers Survation, a survey of over 3,000 people found that they:

- Regarded social care as important to themselves and to those close to them (rising from 44% pre-exposure to 55% after).
- Regarded social care as a benefit to both those who need support and the wider community (rising from 58% pre-exposure to 68% after).
- Placed greater priority to social care above other areas of Government policy.
- Supported more investment in social care from central Government (rising from 60% pre-exposure to 67% after).
- Believed that it's possible to start organising social care in a better and more sustainable way now (rising from 52% pre-exposure to 63% after).

Crucially, the route to achieving these results was to shift mindsets from the limited and limiting thinking about social care outlined above towards one rooted in people being empowered to lead the lives they want to lead through the support and relationships they enjoy in their local community. Following exposure to our new narrative, people were:

- Significantly less likely to associate social care with paternalistic ideas such as vulnerability and compassion (declining from 50% to 27% and from 52% to 36%, respectively).
- Far more likely to associate it with words such as independence, community and relationships (increasing from 19% to 33%, 12% to 31% and 12% to 31%, respectively).

They were also more likely to agree with the statements that:

- 'Social care is about people having the support to live how, where and with whom they choose to' (increasing from 61% pre-exposure to 70% post).
- 'Social care draws together relationships and support' (from 51% pre-exposure to 65% post).

- 'Living how we choose to live is dependent on the strength of the relationships that we have' (49% pre-exposure to 60% post).

NEW NARRATIVE

What is the new narrative that achieved these results? Some of it may already be familiar because #socialcarefuture has been promoting it for almost two years:

'We all want to live in the place we call home, with the people and things that we love, in communities where we look out for one another, doing what matters to us.'

This opening, values-led, hopeful statement establishes in our audience's mind the life that social care should help us all to lead. It invokes values of self-direction, solidarity and belonging. It addresses everyone. Moreover, as the communications expert Anat Shenker-Orsorio reminds us, 'People buy the brownie, not the recipe' – it focuses on people leading good lives, not on the plight of a 'system' or 'sector.'

We then briefly explain why we might need social care, linking it back to the headline vision:

'If we or someone we care about has a disability or health condition during their life, we might need some support to do these things. That's the role of social care.'

Again, while linking social care to health and disability, we avoid presenting it as pertaining to 'others' or fixed groups, using the word 'we' throughout and leaving open the possibility that it is something we may all have reason to call upon.

We then set out how we believe social care should work when working well:

'When organised well, social care helps to weave the web of relationships and support in our local communities that we can draw on to live our lives in the way that we want to, whatever our age or stage of life.'

Here, we introduce the idea of social care not as a single transactional service delivered to people or as a place people go to, but as the drawing together of formal and informal support and relationships on which people can draw to live the lives they wish to. 'Weaving the web' is one of a number of metaphors we successfully tested to create a mental shortcut to this idea, along with social care as 'the glue that binds' and social care helping to 'nurture an ecosystem' of relationships and support. We employed real-life examples to bring these ideas to life, focusing on personal

assistance, wellbeing teams, community circles and local area co-ordination.

Having defined what good social care is, the final stage of our narrative sets out what needs to happen to bring this to everyone:

'We believe that this can and should be happening everywhere and for everyone. For that to happen, the Government must make good social care a priority and begin investing more in it. And more local councils need urgently to start working alongside and supporting local people and organisations to bring these ideas to life by organising and funding social care differently now.'

THE POTENTIAL IS POWERFUL

During the research, some participants rightly noted that as much as they liked our vision and approach, it was not something that could be realised immediately. That needn't, however, mean that we cannot make a start on building it, hence we talk about Government making it a priority and *beginning* to invest more and local authorities needing to urgently start working differently now. There was also some concern expressed during the earlier stages of our research that approaches which involved enlisting support from the community could mean Government absenting itself, hence we implicate central Government, local Government and local people and organisations. Finally, we characterise the nature of the relationship that we believe should exist between local councils and communities by using the phrase *'working alongside and supporting local people and organisations'*.

Of course, the results we are able to share here took place within the simulated conditions of audience research. Various factors will mediate how effective this narrative is in the wider world, including its messengers, how creatively it is delivered, the degree to which it comes to be adopted by social care's advocates, the moments that create opportunities to deploy it, whether the media adopts it and our ability to deliver it at scale to target audiences.

However, what our research clearly demonstrates is the potential to command stronger support for investment and reform of social care and that the positive vision and approach developed by #socialcarefuture offers a persuasive and powerful way to do so.

The research and guidance on how to put the narrative into action will be available later in April at www.socialcarefuture.blog

CMM

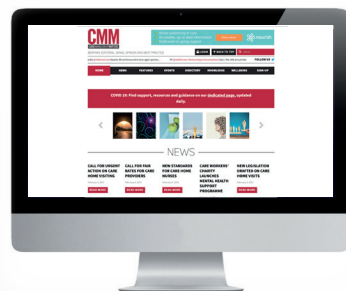
Neil Crowther is an Independent Social Change Consultant. Email: crowtherconsulting@gmail.com Twitter: [@socialcarefuture](https://twitter.com/socialcarefuture)

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LEAD INDIVIDUALS

Julie Hopkins has a depth of experience in looking after businesses in the care sector which few can match, with over 25 years' experience supporting businesses from start up, growth planning through to exit. Accountancy is her profession and the care sector is her passion. She offers vital support to our care business clients, with up-to-date sector knowledge adding value to the breadth of advice given. She is

a well-respected researcher in the sector, contributing to sector-written articles.

Neil Hutchings is Albert Goodman's corporate finance specialist, having joined the firm in 2008. Over the past 12 years, he has developed extensive corporate finance, audit, accountancy and business advisory skills, over a wide range of companies and organisations. Neil has vast experience in the buying and selling of care homes and care home groups and is well-connected within the corporate finance sector.

COMPANY INFORMATION

Albert Goodman LLP, established for over 150 years, has developed a dedicated team to support providers in the care sector to navigate through business challenges, with wider contacts in the sector adding value to the advisory given.

In addition to the accountancy and tax compliance, business advice is given throughout the year through management accounts production, KPI reporting and variance analysis from budget to actual, monitoring occupancy and cash flow, providing timely reporting for in-house management and to meet bank covenant requirements.



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SECTORS

- Elderly residential and nursing homes.
- Learning disability.
- Supported living.
- Domiciliary care agencies.
- Close care/extra care/assisted living.
- Challenging behaviour and special needs.

SERVICES

- Accounts, audit and tax.
- Sales and acquisition advice and support.
- Corporate finance.
- Due diligence.
- Raising finance and refinancing.
- Business performance monitoring.
- Cloud accounting and systems advice.
- Exit planning and preparing the business for sale.
- Tax planning and structuring.
- Estate planning.

COMPANY INFORMATION

Bishop Fleming is a dynamic UK accountancy firm providing a comprehensive range of

services across a range of sectors. The Healthcare team provides help and support to a growing number of health and social care operators, across a wide geographic area. With specialist knowledge spread across seven offices, the team has the depth of experience to help its clients achieve their goals.

We pride ourselves on being relationship led and place our client and people relationships at the heart of our business.

Over the last 12 months we have supported our clients with regular webinars and the creation of our Knowledge Hubs, bringing together the most up-to-date resources to navigate a way through these difficult times.

We have advised our clients on several transactions and continue to see increasing levels of interest in both buying and selling care homes across the UK as we see light at the end of the COVID-19 tunnel!

If you are looking for advice and want to work with a firm that believes: 'it's what we bring together that sets us apart', then call one of our specialist healthcare team.



Tim Godfrey *Partner and Head of Healthcare*

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SECTORS

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- Learning disability/challenging behaviour.
- Specialist needs education colleges.
- Assisted living/close care/extra care.
- Drug, alcohol and eating disorders independent hospitals.
- Domiciliary care.
- Supported living.
- Children's services.
- Secure units.
- Foster care agencies.
- Primary healthcare.

SERVICES

- Accounts, audit and tax.
- Accounts preparation.
- Business planning and advice.
- Corporate finance.
- Tax advisory services.
- Benchmarking.
- Sales and acquisitions.
- Preparing the business for sale.
- Exit planning.
- Valuations.
- Assisting in negotiations.
- Minimising the effects of income tax, capital taxes, VAT and stamp duty land tax.

**Rachael Anstee** PartnerEmail: rachael.anstee@hazlewoods.co.uk

HAZLEWOODS

DRIVING LIFELONG PROSPERITY

- Due diligence.
- Raising finance.
- Estate planning.

COMPANY INFORMATION

In a rapidly changing industry, having informed insight into the challenges you face and business advice from experts in the health and care sector can provide a significant advantage.

Hazlewoods Health and Care team has developed an enviable knowledge and understanding of the health and care sector over the past 30 years, acting for over 250 businesses on an ongoing basis and developing true specialist knowledge.

At whatever stage of the lifecycle your business is at, it is important to have a clear strategic plan, discussing it regularly with advisers who take the time to understand you and your business. Our experts are keen to get to know you and will use their experience and connections in the industry to help you realise your goals and add real value.

Despite the challenges of 2020, overall, we advised on nearly 50 successful healthcare transactions valued at £540 million.

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MORRIS LANE

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SECTORS

- Care homes/nursing homes.
- Domiciliary care agencies.
- Learning disabilities.
- Property development.

SERVICES

- Acquisitions and disposals.
- Accounts and auditing.
- Business plans, support and advice.
- Company secretarial.
- Corporate finance.
- Payroll services.
- Tax advice and services.
- Management accounting.
- Capital allowance claims.

LEAD INDIVIDUALS

Roger Morris heads up the Morris Lane team of specialists working with their healthcare-focused clients. Roger is an award-winning member of the Chartered Institute of Taxation and has over 30 years' experience in the sector.

Roger is ably supported by their lead accountants specialising in the sector,

**Roger Morris** Partner

Tel: 01202 715950

Email: roger.morris@morrislane.co.uk

Michelle Cordy, Jon Hoyle, Michelle Pettifer and Connor Ronchetti, in providing proactive solutions and services to enable clients to achieve their ambitions, to maximise their profitability, and to increase and protect their wealth.

COMPANY INFORMATION

The firm has clients located throughout England and Wales and is believed to advise more care home operators than any other accountants in the UK.

Whilst providing the accountancy and audit solutions you would expect, their real strength is in the quality and timeliness of their advice, whether this is on structuring your business to ensure you are maximising your tax allowances in line with your business strategy, or as part of the purchase or sale of a care home or business.

Morris Lane also works closely with other professional advisers in the sector including banks and solicitors.

CELEBRATING EXCELLENCE IN **SECTOR DEVELOPMENT**



St Luke's Hospice won the Contribution to Sector Development Award at the Markel 3rd Sector Care Awards 2020.

St Luke's Hospice has developed a model of care which is shaping the sector. The St Luke's Palliative Helpline (PALL24) is available to patients, carers and healthcare professionals who need advice and support regarding end-of-life care. PALL24 provides advice and a co-ordination service 24 hours a day, seven days a week. Direct care can also be delivered through their rapid response team. St Luke's has been working closely with the London Ambulance Service.

In the first of a series of features celebrating this year's winners, Dr Charles Daniels, Medical Director at St Luke's Hospice, sheds light on why the hospice was recognised in this category.

STRENGTHENING TIES WITH LOCAL SERVICES

Our 24-hour helpline and referral service, PALL24, is run by a dedicated team of expert nurses who can give advice, provide a rapid response in times of crisis and effectively co-ordinate care, from arranging prescriptions to getting vital equipment delivered – anything people need to avoid going to the hospital and to stay comfortably in their home.

Previously named Single Point of Access (SPA), the helpline was set up in 2015 based on clinical experience where many Harrow and Brent patients, their relatives and healthcare professionals, felt a need to be

able to access 24-hour advice from palliative care/hospice colleagues. In response, we initially set up a nursing service to answer telephone calls 24 hours a day and then supplemented this with further expert advice from consultants in palliative medicine as needed.

This service aimed to provide a co-ordinated, 24/7 telephone service, offering specialist advice and assistance to patients in the last year of life and those individuals caring for them. The project was and still is available to health and social care professionals, including paramedics from the London Ambulance Service (LAS), to discuss patients who are either: (i) already known to the service, or (ii) appropriate for referral. As a direct consequence of the project, communication between the hospice and the LAS has strengthened, facilitating clinical collaboration and improved patient outcomes. One of our driving factors following the introduction of the service was to assess the frequency, nature and outcomes of the calls made to the helpline from local paramedics.

TARGETING AND RESPONDING TO DEMAND

The project was multi-disciplinary-led and involved the collaboration of GPs, district nurses and more. One of the professional

groups that was often identified as being called to the support of palliative patients in the community was London Ambulance staff. In response, we worked together and co-designed a training programme for our local ambulance colleagues and arranged shadowing placements for them to improve their working knowledge. Both of these created a close working relationship and, over the years, we have seen increasing use of our service by ambulance colleagues.

The initial surge of COVID-19 infections saw an even greater need to provide this service. During the first two months of the first national lockdown, the PALL24 team enabled 95% of people to remain at home and not be transferred to hospital, helping to alleviate pressure on local NHS services. Throughout the years, the service has been associated with low rates of subsequent patient transfer to the hospital making it a sustainable and much-needed service to help reduce pressure on the NHS.

MULTI-FACETED SERVICE DELIVERY

PALL24 provides advice and a co-ordination service through a single telephone number 24 hours a day, seven days a week, available for patients, carers or healthcare professionals in the London Borough of Harrow. Direct care can also be delivered through our rapid response team. All calls are answered by registered nurses who are experienced in palliative care, and the nurses can make referrals, signpost them and advise on queries. The service is very integrated, and we collaborate with community palliative nurses, GPs and the LAS. In addition to this, referrals are received for the service. Once the referral has been received, one of our registered nurses will contact the patient to explain the service over the phone. Nurses also do home visits in response to a crisis and relieve symptom control. Our nurses are also able to do verification of death. The team can order equipment for emergencies, as well as set up packages of care to enable patients to die in the comfort of their home.

OVERCOMING CHALLENGES

In contrast to an acute hospital setting, community services can appear siloed. With different teams carrying out their assessment, patients can be confused as to who to contact when there is a new care need. Understandably, families worry whether they will be able to successfully care for their loved ones as death approaches. PALL24 has

tried to bridge these concerns and to reassure the family that there is someone they can call no matter the time or day.

One of the main challenges that we have faced is that the service is only funded for one of the London boroughs that we cover. As the hospice covers two London boroughs, we receive calls from people outside of the funded catchment area, adding pressure on the team to manage the caseload.

During our initial contact with patients, carers or healthcare professionals, we seek to understand any potential difficulties trying to co-ordinate care or to understand which patients in the community have rapidly changing needs. This helps us to plan ahead of time and review any obstacles regularly with other community teams. At Luke's, we are fortunate to have a palliative care consultant available 24-hours, so there is a healthy support system to meet any challenges that we might face.

LOOKING TOWARDS THE FUTURE

We believe in empowering people and that people can receive personalised care in line with their wishes. We are hoping to build on the helpline's current success by contributing to more people achieving their preference for end-of-life care at home. Currently, across the UK, 44% of people who would prefer to die at home do so. This is a rise from 38% a few years ago, so things are getting better.

We have received excellent feedback from service users and their families who have written in to say how thankful they were to receive a high level of quality and timely care and support to enable their loved ones to remain at home. This has been especially valuable during the pandemic, where acute settings could not always accommodate visitors or family until the end of life. We hope to achieve even better outcomes for the project. We will continue to strengthen interdisciplinary relationships between healthcare professionals in the hopes that vital information needed for delivering care is shared simultaneously. Ultimately, enabling more joined-up work, giving patients and their families in the community confidence that their care and changing needs can be seamless, responsive, timely and person-centred, resulting in a 'good death.'

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MARKEL 3RD SECTOR CARE AWARDS 3



Headline Sponsor

The Markel 3rd Sector Care Awards is run specifically for the voluntary care and support sector. Visit www.3rdsectorcareawards.co.uk to 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 Contribution to Sector Development Award was sponsored by Markel Law.



COVID-19 AND THE CARE HOMES OF THE FUTURE

22nd February 2021

This webinar, hosted by the International Long-Term Care Policy Network, heard from a panel of international speakers who have examined care home models from several different perspectives, before and during COVID-19. The purpose was twofold. Firstly, to reflect on the lessons learnt from providing residential care during the pandemic. Secondly, to consider how these lessons will impact on the role of communal living in wider care provision.

STRUCTURING CHANGE

A key theme discussed was in relation to the architecture of residential care homes. Namely, its ability to influence quality of life, its responsibility to create dementia-friendly environments and the inadequacies of current models. Thomas Grey and Des O'Neill, both of Trinity College Dublin, introduced the concept of designing care homes of the future with infection prevention control (IPC) in mind, whilst maintaining essential features to maintain the wellbeing of residents and strengthen their resilience.

COVID-19 has exacerbated long-standing concerns about current design models, with many having a negative impact on older people's quality of life. Due to lengthy periods of quarantine or shielding, many residents have been cut off from their communities, experienced a lack of exercise

or subjected to reduced social engagement. To combat this, the speakers proposed a more integrated, balanced and holistic approach to residential care models, urban planning and architecture of the future.

The speakers reported a growing convergence between architectural design and health and this can be typified by considering the dementia-friendly care homes of the future. Pre-pandemic, care workers were reporting difficulties in their roles associated with design conditions such as poor lighting, constant noise and lack of daylight. Available space also made caring for residents to the expected standard challenging at times. In the future, it is proposed that there must be greater collaboration between designers and clinicians to ensure that staff can provide care without limitation.

LEARNING LESSONS FROM ABROAD

The webinar benefited from the panel's experience of international care settings and how they may influence future models of care at home in the UK. Vic Rayner, Executive Director at the National Care Forum, spoke about the Nordic Care Hotel models, other innovative approaches to care and how they might be introduced to the UK's offer in the future. The Nordic model, namely in Denmark and Sweden, is largely

medicalised and influenced by geography of each nation. Facilities tend to be co-located to cater to the long distances people may have to travel to reach them.

The Nordic model's implication on the UK care sector is limited. In terms of geography, there is a larger concentration of care settings across the country compared to Scandinavia. This undermines the co-located structure promoted by the Nordic model. On the other hand, the Dutch model appears to mirror the UK's offering to a greater extent, advocating a 'home first' approach. Whilst the concept of Care Hotels would still need to be grasped in the UK for the Dutch model to be fully adhered to, the speaker observed that its dominant rehabilitation drive in post-hospital settings is something that could be practicable here at home.

Integrating health and care in the UK has been a long-standing talking point for the sector and the Dutch model of providing support through Care Hotels offers a fresh perspective. Taking a very clear, focused and shared goal around rehabilitating people sufficiently enough for them to return home and live independently, rather than entering a residential setting, is a pathway that could help to meet the UK's integration ambition.

For more information about the topics discussed in this session, access to speaker biographies and a full recording of the webinar, visit the International Long-Term Care Policy Network website.

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STRAIGHT TALK

Michael Fullerton, Director of Health and Wellbeing at Achieve together, says now is the time to empower, not marginalise, people with learning disabilities.



Put simply, the COVID-19 pandemic has illuminated the stark realities of the marginalisation of people with learning disabilities and, therefore, the sector itself. As we begin to catch a glimpse of the light at the end of the COVID-19 tunnel, now is an opportune time to use the learnings of the last year to shine the right spotlight on the sector and put the brilliant people with learning disabilities front and centre stage.

Throughout the pandemic, the approach to social care and the policies that followed often left people with learning disabilities, and the sector, side-lined or left behind. This has largely been due to there being too much of a blanket approach to the varying social care settings, or on other occasions the specialist support sector and the needs of its people being somewhat overlooked. For all corners of the social care sector to deliver the best possible provision, there must be a more personalised, responsive approach which takes all aspects into account.

One of the stand-out examples of discrepancies between the wider social

care sector and the learning disability sector during the pandemic has been the recent vaccine roll-out. Whilst people living in elderly residential settings and their staff were high on the priority list for the vaccine, the grouping criteria created arbitrary distinctions between those who have 'severe and profound' learning disabilities, in contrast to those with 'mild or moderate' learning disabilities. This left a large proportion of people with learning disabilities unvaccinated, and therefore unprotected, for too long.

This was despite clear evidence demonstrating how vulnerable those with learning disabilities are. A report from Public Health England found that the rate of COVID-19 deaths for people with learning disabilities is six times greater than the general population, while the 2020 LeDeR Review highlighted that 65% of people with a learning disability who died with suspected or diagnosed COVID-19 had a mild or moderate learning disability.

Meanwhile, the priority groupings did not consider other related factors, including that many people with learning disabilities live in shared residential settings, often meaning that only a proportion of people living under one roof had received the vaccine and therefore were protected, with others left waiting.

Another example is the recently released roadmap out of lockdown, which includes people in care settings receiving visitors from 8th March, which we really welcome in principle. However, the timeframe set for this has largely been based on the understanding that the majority of elderly residents will have received their vaccinations and therefore be protected. The timeframe does not, however, account for many of those with learning disabilities in care settings still not having received their vaccine and therefore not being protected in the same way.

For too many years, those with learning disabilities have been spoken about, rather than to, when it comes to issues impacting them. As we look ahead to the coming months, and despite

writing this piece on behalf of the people we support, the focus must now be on bringing them in to the conversation – with a permanent seat at the table – if we are to turn these learnings into meaningful, positive change.

Many of the people Achieve together supports are passionate about issues that impact on both them and the sector, and we make sure that their voices are at the heart of every decision we take as an organisation too. Campaign4Change, a self-advocacy group Achieve together has partnered with, has campaigned on numerous issues, from accessibility to changing the language used around learning disabilities. These are who decision-makers need to be talking to when making choices that impact on their lives.

As we move forwards into eased restrictions, for those Achieve together supports and many more people with learning disabilities, the return to 'normality' will be a big adjustment requiring careful planning and gradual changes.

A large element of our work now is preparing people for the return to a busier and more sociable life. To help with this transition, we have been hosting virtual chat events, again putting people at the centre of the discussion around their plans and feelings about what life will look like next. We have also appointed two relationship advisers and part of their role in the short term will be to support people to re-enter 'normality' in a way they feel safe, supported and empowered.

Our approach to providing the best specialist support is all about co-production: it is only when we have involved not just the person but their families and their wider support networks in the decision-making process, that we can be confident they will be supported to live happy, healthy and meaningful lives. Looking ahead, the same collaborative and personalised approach must be followed, if we are to take the temporarily, for many life-changing, learnings of the last year, to really help protect and change lives for the better.

Michael Fullerton is the Director of Health and Wellbeing at Achieve together. Twitter: @MichaelFullert3

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