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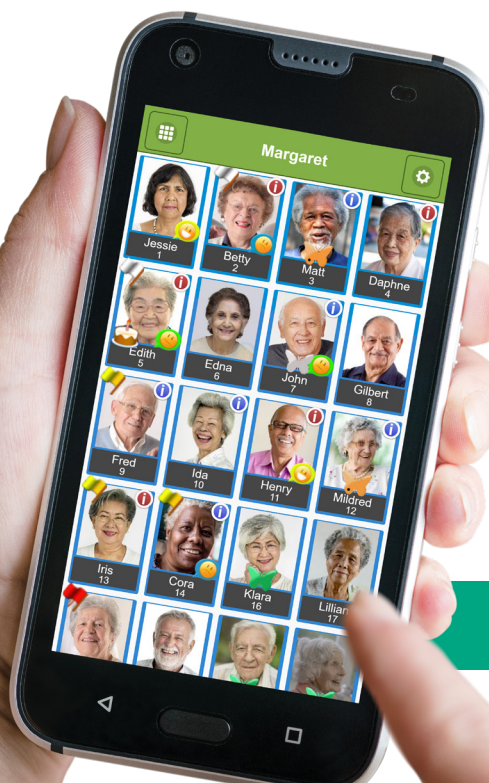
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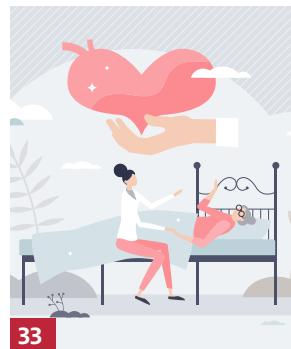


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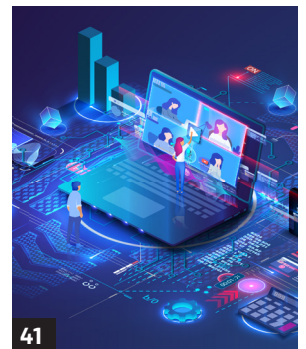


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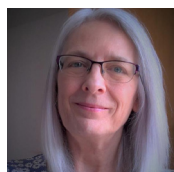


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SOCIAL CARE INSIGHTS

From Simon Bottery



The Government's 'Goldilocks' fair cost of care policy is risky and underfunded, says Simon Bottery, but has built-in pressure valves for local authorities.

Though the 'cap on care costs' has had all the headlines, arguably the most radical Government reform of adult social care is the plan to introduce a 'fair cost of care'. The intention is that local authority commissioners identify what it costs to provide high-quality care – and then pay it.

That would be a major departure from the care marketplace in recent years, which has seen many local authorities pay less for care than a sustainable rate. In turn, to keep providers in business, self-funders have had to 'overpay' for their care, perhaps by as much as an extra 40%.

Now however, the

Government plans to give self-funders the right to ask their local authority to arrange their care – at the rate the local authority would have paid. That threatens to strip providers of the 40% mark-up they have relied upon to balance their books.

This, then, is where the 'fair cost of care' comes in. In essence, it replaces the rate paid by the local authority, which is too low, and the rate paid by the self-funder, which is too high, and replaces them with one single 'fair rate' that is paid by both. It's as if the theme of the Goldilocks fairy story, with its tale of one bowl of porridge being too hot, another too cold

but a third 'just right', had been applied to the care home fees market.

So, by 14th October, local authorities are to have calculated a 'fair cost of care' and said how quickly they will move to paying it. And there is Government money to help them pay the 'fair rate' – £1.36bn over three years. So everyone will live happily ever after, apparently.

The original Goldilocks story, though, is a dark tale which does not have an unambiguously happy ending. Goldilocks does escape from the Three Bears but we are told she may have 'broken her neck' in the escape or gotten lost in the

woods forever.

And it is by no means clear that the Government's 'Goldilocks' fair rate of care policy will end happily, either. While there is support from local authorities and providers for the basic principle, the concern is that there is insufficient funding to make it work. Industry experts Laing Buisson and the County Councils Network have estimated that at least twice as much is needed, just for care homes.

In practice, though, the Government has built in a number of 'pressure valves' for local authorities. These include the potential for a slow pace of change – the Government's language is about 'moving towards' a fair rate of care, rather than having fully arrived there by 2025. In addition, there is no rigid template for local authorities to calculate a 'fair rate'. Instead, they can make their own decisions, even about what a reasonable rate of return on capital for providers might be. Finally, there is flexibility about how it might be applied: the 'fair cost' is not intended to be fixed across all providers in a local authority.

These are wide blurred areas which local authorities may be able to exploit to implement an ambitious policy with limited resources. It may mean, however, that a 'fair rate of care' still feels much less than fair to providers and service users.

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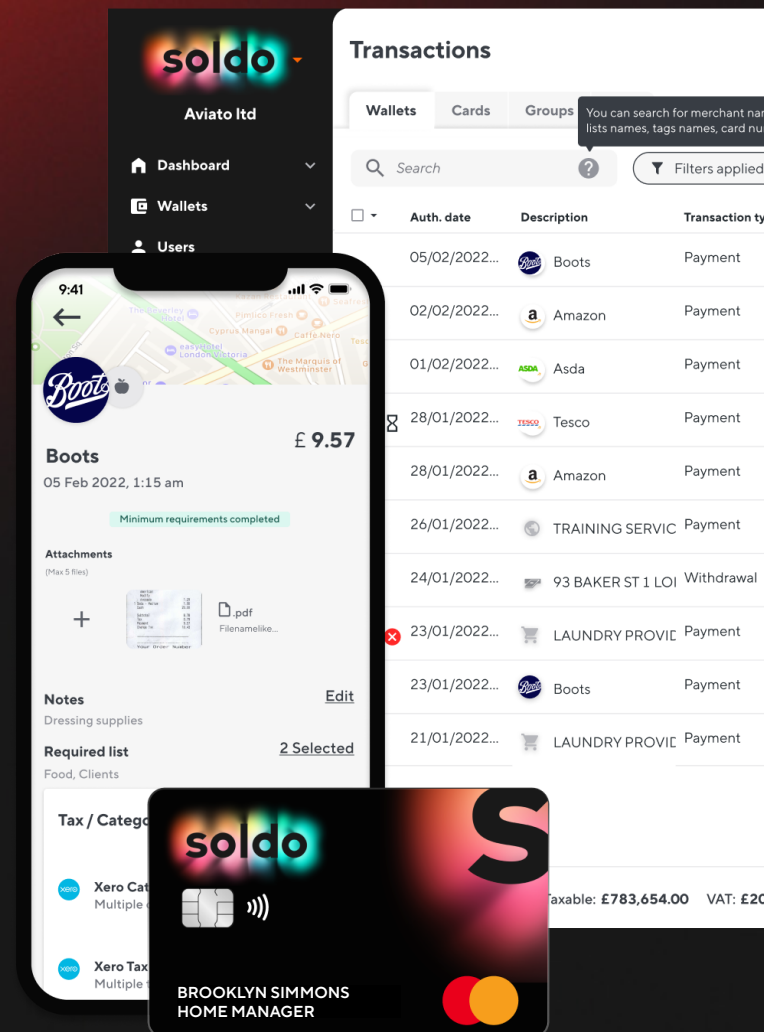
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Cairn Mhor, Residential Care for Children



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Over the past two years, we've seen the world change immensely as a result of the pandemic. Marie Curie held its day of reflection on Wednesday 23rd March, for people to connect and reflect on our experiences, supporting millions of people grieving in such challenging times. I want to thank care workers, particularly those working in services for people with a learning disability and autistic people. My colleagues and I have seen how you've found creative ways to keep people connected to their loved ones and communities during the pandemic.

It is essential that people, their families and carers are at the centre of care planning, so they can be supported to live fulfilling lives in the way they choose.

OUT OF SIGHT

CQC has been concerned about restrictive interventions in mental health and social care settings for some time. Restrictive interventions include restraint, seclusion and segregation. In 2018, the Secretary of State commissioned CQC to review the use of restrictive measures. We looked at this across health and social care, Government, commissioning, local authorities and public services. In 2020, we published our first 'Out of Sight' report, with recommendations.

Last month, we published our latest 'Out of Sight' progress report, which found that not enough has been made since 2020. There are still too many people in hospital unnecessarily and too many people are subject to restrictive interventions. People continue to face challenges with getting the support they need in the community. Moreover, there are still too many people in mental health inpatient services who often stay too long and do not experience therapeutic care.

All this results in further trauma and ill health and further upset for their families and advocates. This must change.

CQC GUIDANCE

We've outlined the part CQC can play in making this change happen; recommendation six focuses on improvements to how CQC regulates services for people with a learning disability and autistic people. We're doing this by ensuring inspectors focus on specific areas that are particularly relevant to people with

Inside CQC

DEBBIE IVANOVA

Debbie Ivanova, Director for People with a learning disability and autistic people at the (CQC), updates on the progress relating to the 'Out of Sight' report and shares the regulator's recommendations on reviewing the use of restrictive measures.



a learning disability and autistic people on inspection. We're developing new tools and approaches to assess, monitor and inspect providers from registration onwards. We're using our guidance, 'Right Support, Right Care, Right Culture', as the fundamental basis for benchmarking that providers should use when setting up services for people with a learning disability and autistic people.

In addition, we are working to improve our regulation of community health services and mental health services. And we're exploring the way we listen to advocates.

FINDING THE RIGHT HOME AND SUPPORT

People are coming together to make these changes but more urgency is needed. The Building the Right Support Delivery Board, led by Gillian Keegan, Minister of State for Care and Mental Health, is responsible for making the changes happen. Organisations like the British Association of Social Workers have helpful resources like Homes not Hospitals, which helps commissioners to develop more community services and, ultimately, aims to close some inpatient facilities.

SUPPORTED LIVING COALITION

Supporting people with a learning disability and autistic people to find the right home is essential because this extends to supporting them being a citizen in their community and having ownership of their lives. In my last column, I spoke about the Supported Living Coalition, which is a CQC action group that aims to be led by people with experience of supported living services. The actions from the group are taken forward by providers, local authorities, housing associations and other key partners. This Coalition continues to meet regularly to explore key themes and understand what can be done to, ultimately, improve services for people.

We would like more people with current or past experience of living in these services to join the Supported Living Improvement Coalition. If you would like to join the group or have consent from someone who is relevant and can advocate on their behalf, we want to hear from you. Contact CQC by email at SupportedLivingImprovementCoalition@cqc.org.uk

Debbie Ivanova is Director for People with a learning disability and autistic people at the Care Quality Commission. Visit www.caremanagementmatters.co.uk Twitter: @CQCProf

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According to the WHO, Covid-19 is mainly spread through the air in aerosols. Rensair's portable, hospital-grade air purifier combines H13 HEPA filtration with germicidal UVC light to trap and destroy such airborne viruses.

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*Source: Inactivation of aerosolised viruses: MS2 bacteriophage (independent test by the Danish Technological Institute).



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NEWS

MPs vote through cap on social care costs

MPs have rejected calls from peers to re-evaluate the cap on care costs, following a vote in favour of the policy in the House of Commons on 30th March.

Despite peers calling on the Government to reconsider the reform plan, MPs voted 247 to 150, majority 97.

A decisive vote in the House of Lords, taking place on 7th March, saw 198 members voting in favour of dropping the policy cap entirely. Despite increasing pressure from critics, it seems the plan is moving forwards.

In September, the Government announced a cap on lifetime social care costs in England, which was planned to begin in October 2023 and set at a level of £86,000. When the possibility of a cap was

first legislated for in the 2014 Care Act, total care costs incurred – including those covered by council funding for those with low assets or income – were to count towards the cap. However, in November 2021, the Government proposed to amend the Care Act so that only the amount someone spends themselves would count towards the cap.

A joint Institute for Fiscal Studies (IFS) and Health Foundation report, funded by the Health Foundation, found that the proposed Government amendment would impact most strongly on those older people with modest levels of wealth. Those with wealth, including their home, of around £75,000 to £150,000 would face the biggest loss of protection

as a result of the amendment. The result is that someone with around £110,000 in assets could lose 78% of their total wealth even after the cap is in place, while someone with £500,000 could use up only 17%. The report showed that people living in less affluent areas, such as parts of the North East, Yorkshire and the Humber and the Midlands, would be most disadvantaged by the change to the cap on social care costs.

The Health Foundation hopes that the House of Lords encourages the Government to think again on these issues and that the Government remains open to compromise before the Bill is passed into law.

Visit the Health Foundation website to read the report in full.

Living with COVID-19 guidance published

Those working in adult social care services will continue to receive free personal protective equipment (PPE), following the publication of the DHSC's 'Living with COVID-19' guidance. Priority vaccinations and boosters for residents and staff will also continue. The DHSC announced that updated hospital discharge guidance has been published, setting out how all involved in health and social care will work together.

Designated settings will be removed and restrictions on staff movement will also be removed. Streamlined guidance on infection and prevention control measures have also now been published.

Outbreak management periods in care homes, which can include visiting restrictions,

have been reduced from 14 to 10 days and people aged 75 and over, residents in care homes for elderly adults and those who are immunosuppressed are now eligible to receive a spring booster jab to top up their immunity to COVID-19.

Under the new plans, free symptomatic testing will be provided for:

- Patients in hospital, where a PCR test is required for their care and to provide access to treatments and to support ongoing clinical surveillance for new variants.
- People who are eligible for community COVID-19 treatments because they are at a higher risk of getting seriously ill from COVID-19. People in this group will be contacted directly

and sent lateral flow tests to keep at home for use if they have symptoms, as well as being told how to reorder tests.

- People living or working in some high-risk settings. For example, staff in adult social care services such as home care organisations and care homes, and residents in care homes and extra care and supported living services, NHS workers and those working and living in hospices, and prisons and places of detention (including immigration removal centres). People will also be tested before being discharged from hospital into care homes and hospices.

Asymptomatic lateral flow testing will continue from April in some high-risk settings.

APPOINTMENTS

ANCHOR

Denise Peart was appointed as a non-executive member of the Anchor Board on 29th March 2022. Denise is Sky's Chief Talent, Diversity and Inclusion Officer, having joined the organisation in 2021 following senior roles at organisations including Marks & Spencer and The Coca-Cola Company. Previous experience was gained at BP, GE Money and Tesco.

ASHRIDGE HOME CARE

Mitch Miller has joined Ashridge Home Care as Managing Director. He is joining the award-winning home care provider based in Amersham, Buckinghamshire and will work closely alongside company founder Trudi Scrivener.

CRAMOND

Cramond Residence has promoted Ross Bijak to General Manager, while Daniela Zampieri has made the move up from Deputy Clinical Care Manager to take over as Deputy Manager.

The pair will play an integral role in the home's expansion as it looks to increase staff numbers to more than 100 in preparation for opening accommodation on the home's top floor for the first time since opening its doors in 2018 and to increase its specialist care offering for residents with dementia.

HALLMARK FOUNDATION

Three new trustees have been appointed to the board of Hallmark Care Homes Foundation to help lead its work on ageing well and improving the quality of care. The charity funds research and innovation and works with partners to maximise its impact.

Christine Whatford CBE, Kirstie McMillan and Steve Cockell bring a wealth of knowledge, experience and skills to lead and develop the work of the charity.

House of Lords Committee calls for evidence

The House of Lords Adult Social Care Committee has published its call for evidence, inviting the public sector to provide its views on what needs to change to create a fair, resilient and sustainable care system.

The Committee was established in 2022 to consider how to improve the planning for, and delivery of, adult social care services in England. It is now launching a major inquiry, 'Lifting the Veil: Removing the invisibility of adult social care'.

The Committee is particularly keen to receive submissions from experts by experience – those who draw on care and support,

and those who care for them. The deadline for submissions is Friday 27th May.

The Committee will focus on three key issues:

- The invisibility of adult social care and its consequences.
- Better support for carers.
- Putting co-production at the heart of care.

The inquiry will, therefore, consider how that entrenched invisibility of adult social care impacts on the lives of people who draw on care and support and the lives of the people who enable them and care for them.

The Adult Social Care

Committee has published a series of questions, which can be viewed on the Parliament website.

Baroness Andrews, Chair of the Committee, said, 'We encourage a wide range of witnesses to come forward and submit evidence, particularly those with lived experience, in the full knowledge that your views are valued and will have an impact on the future of adult social care in England.'

Head to CMM's Straight Talk column, on page 50, to read an extended comment from Baroness Andrews on why the Committee was set.

Care homes could face widespread closures

Care homes could face widespread closures under new social care reforms, new analysis warns.

A report released by health care market specialists LaingBuisson for the County Councils Network (CCN) analyses two key aspects of the Government's adult social care reforms: proposals to make care fees fairer between private and state fee payers by allowing private payers to ask councils to arrange care on their behalf at lower local authority rates; and the intention to introduce a new Fair Cost of Care, which aims to increase care fees paid by councils to make the care market sustainable.

Currently, the Government has allocated £378m per year for councils to pay this new Fair Cost of Care for care home placements and to protect providers from revenue losses when private fee payers are eligible to ask their local authority to arrange their care – and access lower council rates – from October 2023.

However, the study concludes that the Government's allocation 'seriously underestimates' the amount of new funding required and could cause a 'severe sustainability risk' to care homes across the country. Widespread care home closures could leave councils struggling to find beds for those who require care and trigger a deterioration in the quality of care between local authority and private placements.

The report calculates that an extra £854m a year is needed, at the bare minimum, to make the proposals workable by avoiding large-scale closures and to ensure ongoing investment into the social care sector. Care England says that the funding allocated so far could lead to 'catastrophic financial failure' for its providers.

Bluebird Care launches campaign to support Ukraine

Bluebird Care Exeter, North, East, and West Devon is set to raise just under £15,000 to send urgent medical supplies to the southern city of Odesa. These medical supplies will equip soldiers on the ground with essential equipment such as antibiotics, thyroid medication, and essentials such as Sudocrem, which are all in short supply. The Bluebird Care team's first consignment of €17,000 has already been successfully shipped on 18th March.

At Bluebird Care Lancaster and

South Lakeland, staff members, customers and their friends and families came together over two weeks to raise £755 and collect a haul of essential supplies for the front line of the crisis.

Ross Perkins, Director of Bluebird Care South Somerset, West Dorset and Purbeck, who is also a sculptor, will be donating the funds raised from the sale of a number of his artworks to Ukraine. This includes a steel anchor made from aluminium which is currently on sale at The George Hotel in Castle Cary

for £200.

Bluebird Care Rushmoor and Surrey Heath is also donating £5 to the DEC for every supportive thought shared for Ukrainians, with a number of team members already offering kind words. Meanwhile, Bluebird Care's offices across Reading, Wokingham, Bracknell, Windsor and Maidenhead are sending shoeboxes filled with gifts to Ukrainian children and are encouraging others in their communities to take part in their initiative.

Care employers together for Ukraine

Care employers have been working together to understand how they can provide a meaningful employment opportunity for those displaced from Ukraine and other parts of the world and finding a home within the UK.

The National Care Forum (NCF), in association with the Care Provider Alliance, has brought together a wide range of partners committed to offering support. This includes expertise from across national and local Government, housing,

recruitment specialists, legal and immigration experts and regulators.

Employers and partners are working closely with recruitment experts to enable displaced people from Ukraine and other parts of the globe, to identify roles within the care sector, signpost individuals to localised support and ensure that employers work together to provide the best opportunity for those who wish to work.

Whilst this work progresses, the broader support for people

displaced from Ukraine through the Homes for Ukrainians scheme is being clarified. NCF said it is imperative that the desire to work is aligned with the need for displaced people to be connected into wider community and pastoral support.

Vic Rayner OBE, CEO of NCF, said, 'Care employers are pulling together to take action to help. The ideas are progressing at pace, and there is a strong desire to do something meaningful to help the people of Ukraine.'



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New People Plan for social care launches

The Institute of Health and Social Care Management (IHSCM) visited the House of Lords for the launch of IHSCM's ambitious new People Plan for Social Care.

It is the result of a three-month consultation with care providers, managers, leaders and front-line employees, carried out by the IHSCM and the organisation's Social Care Innovators People Plan Sub Committee.

The project sets out a series of recommendations for central and local Governments and care providers, with a mission to build a 'better and brighter future for social care and its workforce', focusing on five main topics:

- Public Perception of Career Image.
- Training.
- Recruitment.

- Retention and Staff Wellbeing.
- Pay and Benefits.

Whilst this People Plan is about the workforce and has been produced with both short-term and long-term reform in mind, it recognises the critical issues currently facing providers (the link between fees/funding received and providers' ability to invest in their own workforces, and the impact on the sector of the mandate of COVID-19 vaccinations for condition of deployment within social care). This People Plan is also keen to highlight the importance of Equality, Diversity and Inclusion (EDI), as well as the need to move towards greener, more environmentally sustainable models of care delivery.

Visit the IHSCM website to read the People Plan in full.

Mental Capacity Toolkit developed

Bournemouth University (BU) has developed a Mental Capacity Toolkit to support health and social care professionals working with individuals whose decision-making process is impaired.

As part of a wider research project funded by the Burdett Trust for Nurses, BU developed the toolkit to enable ethical, legal and informed professional practice and ensure professionals are confident in their understanding of the Mental Capacity Act 2005.

The BU team identified a need for a Mental Capacity Toolkit that was accessible and easily digestible for all health care professionals.

It is a comprehensive guide that enables professionals to make better informed decisions about everyday choices for their patients.

So far it has been accessed by approximately 14,000 professionals and was designed to support a

broad range of practitioners across the health and social care practice.

The toolkit contains sections of the Mental Capacity Act 2005, including assessment of capacity and decision making. These sections are underpinned by interactive user experiences such as videos and quizzes.

Professor Lee-Ann Fenge said, 'Making decisions on behalf of another person can be really difficult, which is why we developed this toolkit to ensure health care workers can do so professionally and ethically, which is the top priority when working with vulnerable patients.'

The Mental Capacity Toolkit is a free resource for health and social care professionals and for friends or family who may have to make decisions on behalf of another person. Visit the mental capacity toolkit website to access.

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CSI publishes new report on care home trends

CSI Market Intelligence has published 'Say Hello Wave Goodbye – Care Home Openings and Closures 2021', its 7th annual report.

Findings show that, despite years of decline, the trend in care home beds is an increasing one despite the challenges providers have faced in the last few years.

According to CSI, care home openings increased by 8% between 2019 and 2020, and by 12.5% between 2020 and 2021, whilst closures were lower in 2021 than in 2019. This means that a net loss of around 1,500 beds in 2019 has become a 440-bed growth in 2021.

Care home closures still outnumber openings and continue to affect thousands of vulnerable people who lose their homes and have to be

found new accommodation. On average, new homes in 2021 registered 54 beds against 32 for those that closed and there is an ongoing shift towards nursing dementia homes.

Around one fifth of closures did so with an inadequate CQC rating (against one in 50 of all care homes), therefore implying care quality as the rationale for closure, whereas nearly half of closures were either rated good or outstanding (against around two thirds of all homes), which suggests commercial reasons for closure.

The report goes on to show that supply levels still vary greatly by the local authority with areas of oversupply and low occupancy levels, and areas with low supply and a lack of choice for the public.

NIHR changes name to include social care research

To emphasise its commitment to social care research, the NIHR will officially become the 'National Institute for Health and Care Research'. The acronym 'NIHR' will remain unchanged.

Since its establishment in 2006, the NIHR has invested over £200m in more than 470 social care research projects across its portfolio, with £90m worth of NIHR-funded social care studies starting in the last three years. Of these, over a third have been funded by the NIHR's dedicated School for Social Care Research.

NIHR-funded research is diverse, exploring a wide range of important issues and has led to a number of changes to social care practice. In one example, a new approach was developed which reduced challenging behaviours among people with

learning disabilities in residential settings by two thirds and was rolled out across 800 residential care sites.

As well as the £200m in direct funding, NIHR has also supported and delivered social care research through its wider infrastructure.

An increase in spending of £5m a year has been dedicated to social care research, some of which will go towards funding an additional call run through the Research for Social Care programme.

The NIHR is calling on researchers, social care practitioners and users of social care services to undertake and get involved with social care research that identifies and addresses current challenges to improve the lives of carers and people receiving social care.



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Sector responds to Spring Statement

The adult social care sector responded largely in disappointment to the Chancellor's Spring Statement.

It was confirmed that a UK-wide 1.25 percentage point Health and Social Care Levy based on National Insurance contributions will be introduced as planned.

There were some welcome announcements, including the news that money for councils in England to support vulnerable households will be doubled to £1bn from April. In addition, the Chancellor outlined his plans to increase the threshold for paying National Insurance contributions by £3,000 from July.

Kari Gerstheimer, CEO and Founder at Access Social Care, said, 'The social care workforce crisis is so bad that there are parts of the country where it is impossible to recruit, social care services are operating with dangerously low

staffing levels and families with loved ones are telling us they are close to collapse. All this is happening at a time when there is more demand for social care than ever before. The social care sector needed more targeted support. We expect to see an increase in safeguarding issues and hospital admissions as a direct result of the failure to address these pressures in this Spring Statement.'

Vic Rayner OBE, CEO of the NCF, said, 'At this stage it is unclear what effect the change in NI thresholds will have on the overall amount of funding for health and social care raised through the NI Levy. The amount of money going from the Levy to support social care is already too low – at £5.4bn out of a previously estimated £36bn – and the Government cannot allow any reduction in the total promised for social care as a result of this Statement.'

Leaders call for action on social care workforce

National adult social care organisations have come together to call on the Government to deliver a long-term care workforce strategy and tackle the issue of care worker pay.

The organisations argue that action on these key issues will help address the serious problem of recruitment and retention and, in turn, deliver better support for people across our communities.

The sector bodies say that, without improving the pay, conditions and career progression opportunities of care workers, it will be difficult to make meaningful progress towards their shared goal of best supporting people to live the lives they want to lead.

They say this is desperately needed to allow for better

workforce planning, including consideration of the types of roles and provision that will be needed in the future, as well as establishing the links that need to be made between the care and health workforces.

The position paper on adult social care workforce is supported by Cathie Williams, Chief Executive, Association of Directors of Adult Social Services (ADASS); Professor Martin Green OBE, Care Provider Alliance (CPA); Jackie O'Sullivan, Co-Chair, Care and Support Alliance (CSA); Simon Williams, Head of Adult Social Care, Local Government Association (LGA); Oonagh Smyth, CEO, Skills for Care; Kathryn Smith, CEO, Social Care Institute for Excellence (SCIE); and Ian McCreath, Head, Think Local Act Personal (TLAP).

IN FOCUS

Management of PPE contracts investigated

WHAT'S THE STORY?

The National Audit Office (NAO) has published insights today relating to the management of PPE contracts in the health and social care sector during the COVID-19 pandemic.

Since February 2020, DHSC and its NHS procurement partner, NHS Supply Chain Co-ordination Limited (SCCL), has awarded almost 10,000 contracts for personal protective equipment (PPE). DHSC has so far spent £12.6bn of the total £13.1bn it expects to spend on almost 38 billion items of PPE.

WHAT WERE THE FINDINGS?

DHSC established two new procurement routes: the Parallel Supply Chain, established in late March 2020; and a new UK Make route, established in April 2020 to purchase PPE specifically from UK-based manufacturers. Some 394 contracts worth £7.9bn were awarded through these two new procurement routes, largely to new or unknown suppliers to the NHS.

To date, DHSC has taken receipt of 31.5 billion items of PPE, with a further 1.4 billion items stored in China and 5.0 billion still to be received. Of the 31.5 billion items received, some 17.3 billion items have been delivered to front-line services and 14.2 billion items remain in UK storage. Between March 2020 and October 2021, it had cost the Department £737m to store PPE, including penalty charges of £436m because it had to store PPE in containers for longer than expected.

DHSC estimates it now has 3.9 billion more PPE items than it needs; around 10% of

the total PPE it purchased. The Department is trying to reduce excess stock by selling, repurposing, donating to other parts of the public sector or recycling. It is currently spending an estimated £7m a month storing these items.

DHSC is also storing 3.6 billion PPE items that it considers are not currently suitable for front-line services, accounting for 11% of all PPE it has received. In addition, some 1.5 billion items of PPE currently in storage are estimated by DHSC to have passed their expiry date and therefore are unable to be distributed.

Through contract cancellations and variations, DHSC has reported that it has reduced costs by £572 million. DHSC continues to manage 176 contracts where it is in dispute, where it believes it may not achieve full value for money, putting an estimated £2.7 billion at risk. DHSC assesses that 35% of these cases will not be resolved until 2023. The primary cause of contractual dispute is the quality of PPE that has been delivered.

WHAT DID THE EXPERTS SAY?

Gareth Davies, the Head of the NAO, said, 'The Department of Health & Social Care is still dealing with the results of its emergency procurement decisions, some two years after it first needed to rapidly buy PPE in unprecedented circumstances.'

'The Department is continuing to manage 176 contracts where it believes it may not achieve full value for money, with an estimated £2.7 billion at risk.'

Open letter to Secretary of State

The Care Workers' Charity (CWC), the Care Provider Alliance (CPA) and the Residents & Relatives Association have written to the Health Secretary, Sajid Javid.

The letter asks for the Government to reinstate the Infection Control and Testing Fund and support care workers in the UK who are still very much facing crisis situations due to COVID-19. The guidance contains an expectation for social care workers to continue to self-isolate if they test positive for COVID-19, potentially up to a period of 14 days, without guaranteed full sick pay as the Government has removed the funding that

enabled this. This is presenting an impossible choice for care workers who are being forced to choose between their wellbeing and that of their families, and those to whom they provide care and support. No other part of society is being forced to make such a choice.

In just the first four weeks of this year, The Care Workers' Charity paid over £113,000 to 2020 care workers in COVID grants, which provide support to those in financial pressure who need to self-isolate. Demand for this support grows day by day at the same time as the available funding is shrinking. During 2020

and 2021, £2,585,519 was paid by the charity to 3,985 care workers.

The charity says the need is now even greater due to the sheer scale of the cost-of-living crisis. The CWC has outlined that the Government must act to ensure that people who use care and support get the care they deserve. This can be addressed by:

- In the short term, the Government must reinstate the Infection Control and Testing Fund for as long as guidance remains in place requiring workers to isolate in order that they receive full pay. Care workers remain some of the

most skilled and dedicated workers in our society and yet are often the lowest paid.

- As the biggest purchaser of social care, central and local Government must ensure that providers are funded adequately to enable proper pay, terms and conditions, including sick pay, for front-line social care workers.

The open letter has been signed by Karolina Gerlich, CEO of The Care Workers' Charity, Martin Green, Chair of the Care Provider Alliance and Helen Wildbore, Director of the Residents & Relatives Association.

Social care sector unites to remember colleagues

The social care sector has come together to honour the work of the adult social care workforce during the pandemic and those we sadly lost.

The past year has been incredibly challenging for the social care workforce, which has continued to work tirelessly and make huge sacrifices in the face of the pandemic. According to Skills for Care, an estimated 922 social care workers in England tragically lost their lives between March 2020 and May 2021.

Skills for Care has created a special film to share stories from people working across different settings in social care, discussing their experiences during the pandemic.

CEO of Skills for Care Oonagh Smith said, 'We encourage those who work in social care, those who draw on care and support, and all members of the public to share their tributes to those people in the social care workforce who have had a positive impact on their lives and communities,

through our online Memorial Wall and Thank You Wall.'

The Care Workers' Charity has actively worked to both remember the social care workforce and to also pay tribute to the care workforce by setting up a thank you wall and a memorial wall on its website. The sector can take this opportunity to thank colleagues and people who have cared for family members. It gives people the opportunity to take a step back and reflect on the past two years. This platform allows

people to read the messages of thanks and see how appreciated they are.

The charity has also set up a fundraising page on JustGiving, enabling people to donate to the charity to give thanks to care workers and to the wider sector. Proceeds will go towards payment of The Care Workers' Charity grants and will be given directly to care workers in need through the crisis grants. Visit www.thecareworkerscharity.org.uk/covid-19-tribute/

Consultation opens on Liberty Protection Safeguards

People who draw on care and health services are one step closer to having their liberty protected, as a 16-week consultation is announced.

The Department of Health and Social Care (DHSC) is publishing the draft regulations and Code of Practice for the Mental Capacity Act (MCA) and the Liberty Protection Safeguards (LPS) for public review. Liberty Protection Safeguards (LPS) are to replace Deprivation of Liberty Safeguards so that the emphasis is on protecting liberties. The new single code of practice will replace the two codes of practice that currently exist for the

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), with LPS set to replace DoLS.

The MCA was implemented alongside a Code of Practice, which now requires updating for two key reasons:

- The existing Code guidance needs updating in light of new legislation and case law, organisational and terminological changes, and developments in ways of working and good practice.
- The new LPS system means that additional guidance needs to be added to the Code.

LPS regulations:

- The LPS were introduced in the Mental Capacity (Amendment) Act 2019. The UK Government is now consulting on six sets of draft regulations which will underpin the new system. When enacted, four of these sets of regulations would apply in England only. The remaining two sets of regulations would apply to both England and Wales.
- Separately, the Welsh Government has published four sets of regulations which would apply in Wales.

DoLS have long been criticised and the safeguards developed

to protect the most vulnerable within our communities have at times been seen to fail. The Care Act 2014 launched the legislative shift to strength-based support for adults who draw on care and support. The sector now has a duty to have regards to individual wellbeing, to begin from a position of strength and to support individuals to have choice, control and personal dignity. The Care Act 2014 and LPS provides the legislative framework to enable social work practice to support its profession's underlying principles around enabling human rights and supporting people to live lives important to them.



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State of Ageing report published

The Centre for Ageing Better has launched its annual 'State of Ageing Report', a comprehensive view on ageing in society.

The report, which includes analysis of public and Government data sets, shows that prospects as we age are getting much worse amidst a steep rise in pensioner poverty. A further 200,000 people of pension age fell into poverty in the last year, data shows.

The number of people aged 65 and over in England is set to increase by over 20% over the next

10 years. And yet, the experience of being older in England is becoming considerably worse for many.

Inequalities continue to deepen – net non-pension wealth of the richest 20% of people doubled between 2002 and 2018, while that of the poorest 20% fell by 30%, highlighting a growing divide between the richest and poorest in society.

The report highlights other trends that will have a significant impact on people's security and quality of life in old age. These

include increasing numbers of older people living alone, with 1.3 million more people aged 45 and over living alone in 2020 than in 2000, and the number of people aged over 55 privately renting homes reaching an all-time high of 867,000.

The polling also shows that the public expects both central Government and local authorities to take greater action to ensure a good later life for all.

Carole Easton, Chief Executive at the Centre for Ageing Better,

said, 'It's abundantly clear that not enough is being done to support everyone to age well. The Government cannot shy away from this. With an ageing population, these problems are becoming more and more urgent. The Government must show that they are serious about supporting everyone to have a decent old age by committing to a long-term strategy and by developing the legislation to create an Older People's Commissioner as soon as possible.'

Providers invited to bid for tech bed funding

Care providers are being invited to apply for grants of £75,000, so they can test out with older people which technology tools and digital housing services work best for them and explore why.

The funding is part of the Technology for our Ageing Population: Panel for Innovation

(TAPPI) project, led by the Housing Learning and Improvement Network (Housing LIN), the TEC Services Association (TSA) and funded by the Dunhill Medical Trust, which is calling for 'care-ready' digital infrastructure to be woven into the fabric of all new and retrofitted homes, right from design stage.

The first phase of TAPPI concluded in 2021, examining current practice and then setting out 10 practical principles for using technology in housing and care for older people. The second phase will trial the use of these principles in people's homes over a 12-15-month period.

Four organisations will each be awarded a grant of £75,000 so they can try out different mainstream and specialist technologies with older people, gathering their feedback.

For further details on how to apply, visit <https://dunhillmedical.org.uk/apply-for-funding/>



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NEWS FROM ACROSS THE GLOBE **NEW**

Nearly 40% of people in Japan feel lonely

According to an online survey, conducted in February by organisations including Tokyo non-profit Anata no Ibasho, nearly 40% of adults in Japan feel lonely as social interaction remains limited due to the COVID-19 pandemic, a recent survey showed.

Younger people tend to feel more isolated, according to the

online survey. Of the 3,011 people aged 20 or over who gave valid answers, 37.3% said they feel lonely.

There has been no major change in the proportion since April 2020, shortly after the pandemic began. The survey found that 39.5% of men and 35.1% of women are experiencing loneliness.

Of the respondents feeling

lonely, people in their 20s made up the largest group, at 42.7%, followed by those in their 30s, at 41.6%, those in their 40s, at 40.5%, those in their 50s, at 38.4%, and those in their 60s or over, at 23.7%. Of respondents who said their livelihood has worsened due to the pandemic, 47.8% said they feel alone.

The survey showed that people with lower incomes, along with those who live alone, tend to feel lonelier. 'It is often ignored that young and middle-aged people tend to feel lonelier than elderly people,' Anata no Ibasho said, pointing to the need to address younger generations' loneliness.

One in five care staff plans to quit in Australia

A survey has revealed that one in five aged care workers plans to quit their jobs in the next year after feeling hopeless, exhausted and 'demoralised' in the wake of the COVID-19 crisis.

The Australian Nursing and

Midwifery Federation (ANMF) research showed almost 60% of staff in the industry plan to quit their current jobs within the next five years.

It found 21% of aged care staff plan leave within the next 12

months, and another 37% want to quit their jobs within one to five years.

Of those who plan to quit their current jobs, 16% intend to leave the industry completely, 43% plan to stay in their profession and 27%

were undecided.

The union shared heartbreaking stories from the sector's frontline with chronic understaffing and feelings of being undervalued contributing to the mass exodus.

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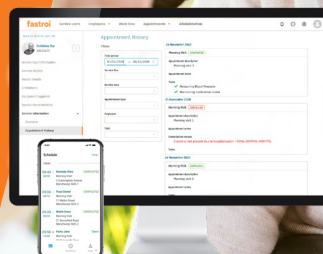
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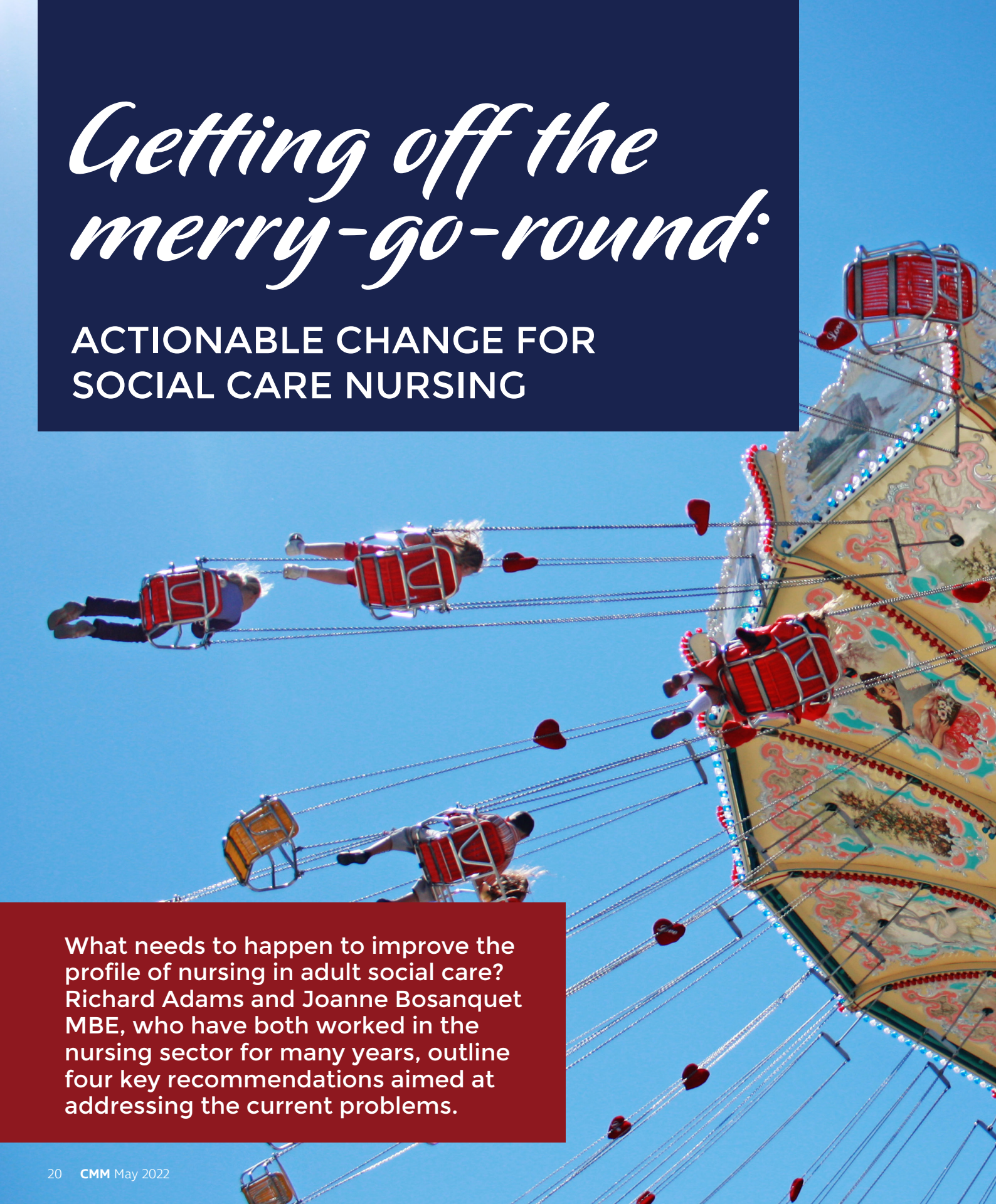
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Getting off the merry-go-round:

ACTIONABLE CHANGE FOR SOCIAL CARE NURSING

What needs to happen to improve the profile of nursing in adult social care? Richard Adams and Joanne Bosanquet MBE, who have both worked in the nursing sector for many years, outline four key recommendations aimed at addressing the current problems.





TIME FOR ACTION, NOT JUST REFLECTION

For those of us who have worked in the sector for some time, we are well aware of the various calls to action to improve the profile of nursing in adult social care. These calls have had a particular focus on care homes. The authors of this article have been involved in a number of roundtable conversations, reference groups, research projects and individual initiatives, all aimed at addressing this issue. Whilst these endeavours offer a solid foundation for identifying why nurses in adult social care feel such disparity with NHS colleagues, and many recommendations to address the problem are proposed, there is, seemingly, very little tangible action and the most common response remains that 'it's complex'.

A recent roundtable hosted by Nursing in Practice¹, with a number of representatives from the sector, highlighted some areas where changes could be made but left us wondering what needs to be in place for these frequently called upon recommendations to become actions embedded in practice.

In this article, we reflect on some of the actions that have been proposed through the various forums, including student nurse placements, developing career pathways, ensuring that nurses in social care are connected to one another and how nurses in the sector can influence decision-making at local, regional and national levels. Our aim is to suggest some practical steps that nurses in adult social care can take to start to bring about sustainable change.

STUDENT PLACEMENTS

Our starting point is the same as that of many nurses – our undergraduate experiences. A nurse's perception of adult social care is seeded very early on in their career. We all have stories to tell of students (and, in fact, experienced nurses) leaving hospital-based settings for community-based settings, with worries about becoming de-skilled and careers being stifled – or worse, over. Whilst this is patently not true, it is a myth that persists. How often do we hear of students' shoulders slumping when they find out their next placement is

in a care home? It is vital we start to work to combat this. In England, we have an incentive. Our Government is focusing on expanding placements as part of its policy work on recruitment and retention of the nursing workforce².

We must understand what expectations the students have of their placements and have a plan for how these can be met. There is a wealth of information on what makes for a good placement³. We need to explore this, look at the areas of best practice for welcoming students, familiarise them with the care home environment and find the best ways of supporting them on their placement.

Reaching out to university placement officers and Skills for Care (and equivalent in devolved nations) regional locality managers and developing a relationship with them will help both the university and the care home to develop the placement offering so that students get the most out of placements in each part of their programme.

Most importantly, students on placements in care homes need to be exposed to the richness of experiences from working as nurses in adult social care: being immersed in relationship-centred care, being part of MDT meetings, taking part in quality improvement projects and practising their management skills – not just being seen as another pair of hands or a distraction.

CAREER PATHWAYS

Having provided a positive student experience, we need to be able to recruit and retain our newly registered nurses, as well as attracting nurses further on in their careers into the sector. There is a perception that persists that there is no career pathway for nurses working in adult social care. Experience and research show this is not the case. Care home nursing requires highly developed leadership and influencing skills⁴. Nurses in social care work at many levels in care home (groups) and supporting organisations, from registered nurse roles working on care units, right the way through to CEOs (as is the case for both the authors of this article): the breadth and scope of roles in the sector is considerable, including clinical, quality improvement, education, >

➤ research and management roles. One example is Dr Karen Rennie⁵, who completed her PhD as an early career nurse and is a care home nurse and lecturer in Scotland.

Whilst structural career pathways are not always well articulated within the sector, there are some excellent examples of career pathways starting to emerge (for example, at the Erskine Trust⁶). We are not always good at seeing things that are not presented to us, so it is vital that we improve the ways in which we talk about and demonstrate to people outside of the sector what careers in adult social care look like and shout about the development opportunities that exist.

There is a need for a more powerful narrative through personal, powerful and authentic stories in our own voices: not just the voices of senior people but the voices of nurses in all parts of the sector. Such stories should help to assuage the concerns of nurses further on in their careers who may have qualms about joining the sector and reduce the perceived risks of leaving the safety of the NHS. Fear of the unknown can be a barrier to nurses moving into the sector. The more we tell our stories – the more the unknown becomes known.

CONNECTING SENIOR NURSES TO ONE ANOTHER

The power of stories connects people to one another. Recently, we all acquired a shared story of nursing through a pandemic. Prior to this happening, it felt like there was a disconnect between nurse leaders in the sector and senior nurses in other parts of the profession⁷. It is easy to speculate on the reasons for this, not least how the careers of each are developed in isolation of one another. However, we need to be honest with ourselves: how hard do we try to reach out and make connections – both within the sector and outside of it, and across the system?

Much of the funding for the development of nurse leaders either does not apply or does not actively encourage applicants from the sector. Instead, it tends to focus on those providing NHS services, which makes developing connections more difficult. We need to explore the leadership programmes that are available and look at how we can be part of these, as well as how to develop our own programmes across the sector. There are some opportunities, such as those provided by the Foundation of Nursing Studies⁸ and, more

recently, The King's Fund⁹. Yet, despite this, we need to find a way to make connections across a wider spectrum of the profession. Both authors have the privilege of being Florence Nightingale Foundation Alumni. We also benefit from being part of a wider network of nurses and being connected to different parts of the profession. These networks give us a voice, both as individuals and collectively, and this is probably not exploited enough by our sector.

INFLUENCING DECISION MAKING

Having a voice is important. Care homes are part of the health and social care system but are often seen as a problem to be fixed, rather than being a partner with an equal contribution to make to the local health economy. Nurses outside of the sector lack a clear understanding of the differences between residents and nursing homes, or those units within the same home: in the same way, we could not claim to understand how a hospital works. However, because of this lack of understanding, there is a risk that we end up being endlessly done unto, rather than leading the change we need to see.

We have a new Chief Nurse for Adult Social Care, which gives us a figurehead, but one person cannot 'fix' all the problems in the system. This role is only part of the solution, not the whole solution. We need a more collective voice which doesn't rely on key individuals, other groups or organisations to speak for us.

Care home nurses need to influence the system. We need to be part of local networks, not just attending but actively participating in the decision making. We also need to have reach across the profession, raising the issues that affect us and challenging the unconscious bias held by policy and decision makers where care home nursing is concerned. We need to make sure that adult social care is better represented in academia, research, policy and strategic planning, as well as in practice. We need to make sure our voice is heard at the highest levels.

FINDING OUR VOICE

Our aim at the start of this article was to look at some of the calls to action that keep being repeated over the years at roundtables, reference groups and stakeholder meetings. We have explored four key themes that

continue to emerge time and again, and the recommendations associated with them. Our aim has been to suggest some positive action that we can take as care home nurses to translate these recommendations into tangible action. We hold the view that we need to act for ourselves and not wait for someone else to do this for us.

We have covered a scale of practice starting with student nurses, looking at career development, focusing on making connections across the profession and finishing with finding our voice. We finish with a further call to action. We are a country with an ageing population and one with increasing care needs. We are the experts in the care of older people. Perhaps now is the time for us to develop a group for care home nurses, run by care home nurses, which can be a voice that speaks to – and for – us?

If ever there was a time to find our voices, that time is now.

CMM

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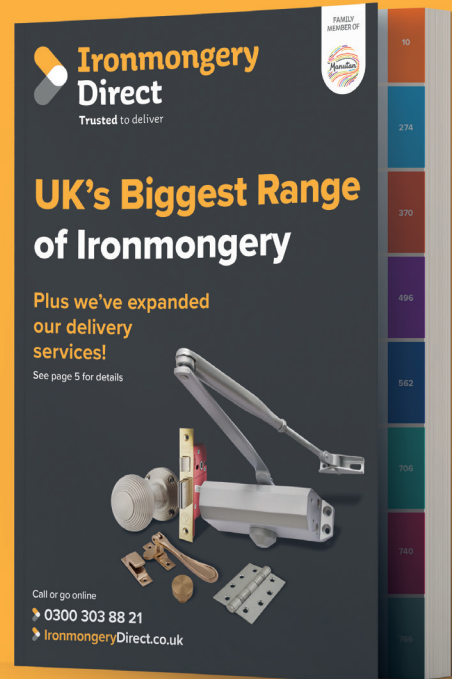
Are you actively involved in transforming the picture of adult social care nursing? How have you helped to call for action and what would your comments be on the action points outlined in this article? Visit www.caremanagementmatters.co.uk and share your feedback on the article.

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Widening the pool:

We need to find more care workers
on an industrial scale

Following up on his recent CMM
feature, Recruitment Specialist
Neil Eastwood considers the
sector's options for sourcing
new talent.

Recent events have plunged the adult social care sector into a deep recruitment crisis. The sudden scarcity of candidates, on top of the longstanding challenges of sourcing suitable care workers to meet demand, which I explored in my recent CMM article, has seen the vacancy rates for all social care roles increase by 63% from March 2021 to February 2022. With almost 10% of roles now going unfilled, rising to 12.8% in home care, we have a serious challenge ahead of us just to meet care demands today, let alone in the future. It is likely the vacancy rate will continue to climb through 2022 as exiting staff aren't replaced and pressure builds on those remaining. >

> The scale of this shortage means that we must quickly identify very large groups of people who are not only keen to take on a paid care role and all it entails (such as unsocial hours and hard work) but who have the right values, will stay long term and will fulfil the basic requirements of the role (like having access to transport). They must also be willing to work for low pay, since there is no sign of a meaningful across-the-board pay rise that recognises the contribution of care workers. And we need to find them urgently. This means we can't expect to have addressed the systemic challenges I explored in my last piece, aside from low pay: how care workers are valued and changing workplace attitudes.

“In Australia, 37% of the workforce are migrants. Were we to boost our workforce and halve the gap with Australia by adding a further 10% of immigrant workers, that would be enough to fill all our current vacancies.”

As a longstanding observer of social care labour markets, it is my view that we must focus most attention on three pools of labour, which are both big enough to supply what we need and contain enough people with the key characteristics employers should seek. Let's look at each one in turn.

1. MIGRANT WORKERS

Before the pandemic and Brexit, foreign nationals made up 16% of the social care workforce. The huge populations of potential migrant workers living close by in EU countries mean that much of our shortfall of labour could, in theory, be made up from this group alone. At the time of writing, there is also the potential for large numbers of refugees to settle here from Ukraine – there have been about 60,000 applications so far – some of whom might join the sector. There are many uncertainties around the practicalities and a much smaller number of visas has been granted. It may be some months before the impact becomes clear.

But it is not just the sheer numbers of



potential migrant care workers that make this group attractive, it is also their renowned work ethic. Foreign-born staff work longer hours in care (about 16% more on average) than their UK-born colleagues and employers regularly tell me of their greater flexibility and willingness to pick up night and weekend shifts compared to the domestic workforce. They are often over qualified for the job they do and represent a committed, valuable and flexible workforce.

But Brexit, exacerbated by COVID-19, has effectively closed off the EU labour pool. Adding care workers to the Shortage Occupation List, as has been implemented recently, is nowhere near to being a remedy as it currently stands. To qualify, sponsored workers must be paid the equivalent of £10.10 an hour, where most domestic care workers will be paid the national minimum wage of £9.50 per hour for over 23 year olds from April.

A return to full and free movement of EU migrant labour is the minimum requirement

to see meaningful numbers make the choice to join our sector. This should be combined with incentives to bring in nurses and care workers from other non-EU countries. These incentives should be both focused on the employer – simpler paperwork and cost subsidies – as well as financial support for workers to settle in the UK. Employers, particularly in South East England, are concerned that, after the effort of bringing in an overseas worker, there is the risk of them seeking new sponsorship from an employer in a lower cost area of the country, or moving to the higher-paying NHS.

If we can get this right, there is the potential to go beyond the pre-COVID, pre-Brexit figure of 16% EU-born care workers. In Australia, 37% of the workforce are migrants. Were we to boost our workforce and halve the gap with Australia by adding a further 10% of immigrant workers, that would be enough to fill all our current vacancies. But first we must become much more welcoming. >

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> 2. FAMILY CARERS

My long experience of identifying the traits of high-performing care workers has highlighted family care experience as by far the best predictor of success in the role. Research undertaken for the Department of Health and Social Care in 2018 also discovered that those who know someone receiving care are over three times more likely to consider working in the sector themselves than someone who has no contact with social care.

“The untapped potential of the personal connections of our existing care workforce is, in my view, the pool of labour with both the most promise and the easiest potential to convert at scale.”

Are there enough of them? Family carers in the UK numbered almost seven million adults before the pandemic. Studies suggest 4.5 million people were forced to become family carers during COVID-19. This means that perhaps one in eight adults in the UK now has direct experience of care and so represents a high potential pool of future paid carers. There is also evidence from other countries that suggests a large minority of those who previously cared for a loved one would consider paid care work. With increasing financial pressures on carers, more may be looking for flexible local work which directly utilises their skills and experience. In the US, programmes such as ‘Cash and Counseling’ allowed family carers to be paid to provide care, especially where there was no other paid care available. After that caring requirement had ended, usually through bereavement, studies discovered that 47% continued in paid care roles. Amongst the 53% who left care work, over 40% said they would consider paid care work again, even for someone not related to them.

The challenge with converting people

with unpaid care experience to paid care work is identifying and reaching them in sufficient numbers. There are few channels available to recruiters – hospice support groups and families of those being cared for by the provider being the most obvious two. So, whilst this remains a prospective pool of the right size and quality, conversion at scale would require a major targeted outreach effort with the support of carer charities, local authorities and central Government.

3. EMPLOYEE REFERRALS

The untapped potential of the personal connections of our existing care workforce is, in my view, the pool of labour with both the most promise and the easiest potential to convert at scale.

There are approximately 900,000 care workers in the social care sector in England alone. Based on sample polling, 69% of them would be willing to recommend a care role to their friends and family connections. Despite this widespread willingness to encourage those they know to join the sector, we estimate that less than 7% of new starters in adult social care each year currently come via an employee referral scheme. This gap represents a significant potential recruitment opportunity, especially when you consider that candidates referred by the existing workforce are 10 times more likely to convert to employees than applicants from an internet job board – a conversion ratio that could become even more important given the paucity of job seekers reported by employers across the country.

The reasons referred candidates have such a high conversion rate is primarily because they are picked for their values by someone who both knows them well enough to identify it and understands the job role better than most recruiters, but also because they can sell the role very convincingly. Adult social care has long had an attraction challenge that can be most effectively (or some might argue, only) overcome by a direct approach from a trusted source on a one-to-one basis. Traditional recruitment advertising neither has this impact nor the ability to target suitable, high-potential people, hence the much poorer conversion rates.

What potential is there to increase the flow of new starters from this source? Our experience from digitising and gamifying this channel at Care Friends is that there can be a three- or more-fold increase in hires.

Generally speaking, for most employers, it seems to top-out at between 25% and 30% of all new starters in a 12-month period. So, a very welcome boost of high-quality, long-staying care workers from a single digit baseline, but numbers can be very much influenced by how well valued staff feel by their employer. Another reason to make every effort to be an employer of choice.

MOST NEW STARTERS DON'T HELP THE SECTOR GROW

Currently, only 37% of the over 490,000 people who start a new role in social care each year are coming from outside the sector. Care workers moving from one care employer to another do nothing to grow care workforce capacity. In order to fill our vacancies, we must encourage new people to join the sector. All three of the pools of labour above will perform better than the current average for bringing in what I call ‘new to care’ candidates. By definition, any migrant worker who is not already employed as a care worker here will be new to care. By pitching a role to family carers, we can expect that the vast majority won’t already be in paid employment as a care worker and employee-referred new starters are typically 33% more likely to be from outside the sector than those from dominant recruitment sources such as internet job boards.

It is my view that, in order to stand any chance of filling our growing vacancies, we must not waste time and money trying to compete with other employment sectors for job seekers who are primarily motivated by finding local work which pays the most money. Rather, the sector should focus our resources where research tells us the largest pools of high-potential, high-converting future care workers are. That means all three of the above.

CMM



Neil Eastwood is Founder and CEO of Care Friends and author of ‘Saving Social Care’. Email: neil@carefriends.co.uk Twitter: [@stickyneil](https://twitter.com/stickyneil)

Have you explored any of Neil’s recruitment strategies and what challenges does your organisation face in tapping into new talent pools? Visit www.caremanagementmatters.co.uk and share your feedback on the article.

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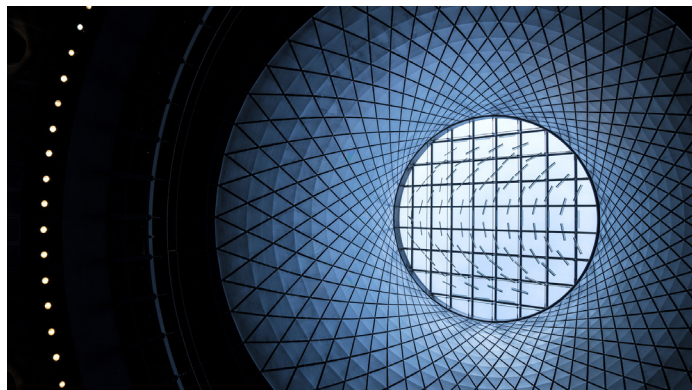
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WHAT IS IT LIKE TO DRAW ON ADULT SOCIAL CARE TODAY?



On Monday 21st March, the Adult Social Care Committee held its third public evidence session, to explore the current adult social care system with a panel of individuals receiving social care. The session examined the changes that people with lived experience would like to see made to services. Topics included the 'invisibility' of adult social care, the assumption underlying adult social care that individuals have family or friends who can provide unpaid care and support, and the relationship between unpaid carers and those for whom they care. CMM has been fortunate enough to receive input for this feature from two of the session's contributing organisations as we aim to get a greater understanding of the adult social care sector from the people who draw on its services, against the backdrop of reform.

THE ISSUES

It has been widely documented that adult social care has had its weaknesses identified by successive Governments, all of whom however have failed to introduce meaningful reform to improve the lives of people drawing on the sector. In its 2019 report, 'What's your problem, social care? The eight key areas for reform', The King's Fund outlined the sector's fundamental shortcomings at the time.

Although steps have been taken by this Government to address these issues through proposed reforms, concerns remain that the sector will continue to be ill equipped to meet the needs of people drawing upon it. Of those issues highlighted in 2019 by The King's Fund, those most applicable to people drawing on the sector are unmet need – people going without the care and support they need; a decline in the quality of care; disjointed care – delayed transfers and lack of integration with health; and a postcode lottery – meaning unwarranted variation in access and performance.

WHAT HAS BEEN DONE?

In December 2021, Government published 'People at the Heart of Care – Adult Social Care Reform White Paper', its long-awaited plan for reforming the sector. The White Paper focuses in part on empowering people who draw on care, unpaid carers and families. Key ambitions outlined include an increased presence of user-friendly information and advice that is inclusive of communication and accessibility

needs, and empowering people to know what their rights are and where to get information and advice on all the options for health, care and housing. Government's vision for people drawing on adult social care also promotes a greater understanding of the local support that is available and that tailored information and advice is provided to support people that may be caring for someone else. Amongst other reforms set out in Government's 'Building Back Better: Our Plan for Health and Social Care', and 'Joining up care for people, places and populations', there is an emerging framework designed to improve the experiences of people drawing on the sector.

THE FUTURE

A recent webinar accompanying the co-published report 'Universal Quality Social Care', saw Anna Severwright, a convener of Social Care Future, discuss the importance of keeping people drawing on adult social care at the centre of integration between health and social care, especially in the case of commissioning services that genuinely serve the interests of individuals in their local communities. Indeed, Social Care Future is a growing movement, aiming to challenge and change the present through action at all levels to close the gap between ambition and reality. With reform gathering momentum and a sector that will continue to demand accountability from Government, the future holds great potential for people drawing on adult social care if the right steps are taken.



Hanging on by a fingernail

**Dan White, Policy and Campaigns Officer,
Disability Rights UK**

Tens of thousands of disabled people still can't access adequate or any social care. Family carers are filling the gaps, often at breaking point. For disabled people who don't have family or friends who can help out, the risks for health, safety and wellbeing are substantial.

The lack of social care often results in disabled people being hospitalised as there is no alternative care provision.

People are often stuck in hospital for long periods, piling pressure on the NHS as it struggles with the pandemic and backlogs for routine appointments.

The pandemic saw social care continue to buckle even as Government announced an extra £2.9bn for crisis support. While it sounds vast, this does not match ongoing need.

The system also fell foul of Brexit, with many foreign care workers returning home to the EU before we left it, although Government, in a move to plug severe staff shortages, later expanded the Health and Care Worker Visa Scheme to include such workers.

However, the situation for thousands of disabled people is far from fixed. We often hear

about the plight of older people, which is ever-present, but alongside them, disabled children, young people and working-age adults are still missing out on essential support.

Government recently proposed plans to overhaul social care, announcing a lifetime cap (£86,000) on an individual's personal care costs. The proposal was largely based around protecting older people who had already built-up assets and owned a home.

The same applies to working-age adults who have not had the opportunity to build up any wealth or assets. To qualify for free care, they must reach the cap, in essence, losing a decade or longer paying for social care charges from their benefits before they can even begin to think about building a life for themselves.

Disabled people must not be put in a position where we must use welfare benefits that enable us to survive to pay for social care instead.

It remains to be seen what the impact of the policy will be – I think it will leave thousands hanging on to solvency by a fingernail.



Something's not right

Tricia Nicoll, Director, Tricia Nicoll Consulting

For me, it's like playing cards with a six-year-old who wants you to play their made-up game that has 156 rules... that keep changing. Above all, it's exhausting.

We all know and love our NHS. We all have our lived experience, even if it is just going to our GP. We know what it stands for and we know how we expect it to work.

However, the average person on the street generally doesn't understand social care or expect it to touch their lives.

Imagery around social care is divided between people with their arms round an older person or headlines about children failed in the care system.

This is linked to how society sees older and disabled people and how we value their lives.

We don't assume that an older person wants to stay in their own home, that a young learning-disabled woman wants to have a baby, that someone with a long-term mental health diagnosis might hold down a position as a senior executive (or a social worker!), and that to do this, they might need to draw on the support of social care.

But, and this is the key, in ways that work for them.

In most aspects of day-to-day living, we are encouraged to dream about how our lives could be better, about aspirations and ambitions, but social care focuses on needs and eligibility.

It is transactional, time and task based and intentionally rationed.

It operates from a Blue Peter-like principle: we'll assess your need, and you can have a service we prepared earlier. Sorry if it doesn't fit that well.

Or you can of course have a personal budget that you can take as a direct payment, but the system is going to have lots of hoops you have to jump through and rules about how that budget gets spent.

Last month, a panel of professionals spent three meetings discussing whether or not a specific item costing £1,200 should be included in my daughter's £120,000 per year budget.

And the daft thing is, when I work with social care practitioners, they're often pretty miserable too.

Something's not right.

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Respecting lives

Why access to specialist palliative care is vital

End of life charities and organisations have been campaigning for some time to ensure palliative care is appropriately recognised in the Health and Care Bill. Claire Towns and Gemma Allen, of The Mary Stevens Hospice, explain the story so far and the impact of the new amendments.

The Health and Care Bill, announced in 2021, defined and proposed to improve the delivery of health care services, integrate care and improve population health across Integrated Care Systems. Yet, at the time of the initial publication, palliative care was not recognised within the Bill.

According to the World Health Organization (WHO), palliative care is defined as:

'...an approach that improves quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention of suffering by early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual'.

Data from Marie Curie suggests that approximately 215,000 people currently do not receive end of life care. Furthermore, many people experience barriers to equitable palliative and end of life care including Black, Asian and minority ethnic communities, people with learning disabilities, LGBTQ+ and other underserved groups.

CAMPAIGNING FOR CHANGE

Prior to the publication of the Bill, several charities including Marie Curie, Hospice UK and Together for Short Lives, led by Baroness Finlay of Llandaff, ➤



➤ campaigned for a change to the Health and Care Bill in the House of Lords to include palliative care as a fundamental health care requirement.

Following months of lobbying, the Government approved the amendments to the Health and Care Bill to include a change of law in the commissioning of specialist palliative care services throughout England.

Responding to the news of the amendment, Baroness Finlay said, 'For the first time, the NHS will be required to make sure that there are services to meet the palliative care needs of everyone for whom they have responsibility in an area. People need help early – when they need it, seven days a week...disease does not respect the clock or the calendar.'

The Health and Care Bill will now ensure that Integrated Health Care Systems and health commissioners legally consider palliative care as an essential requirement and available to all.

CHANGES IN PRACTICE

Current specialist palliative care provision is often deemed as being a postcode lottery; however, the Bill now requires that dying people have a legal right to access palliative care across every area in England. With the demand for palliative and end of life care expected to increase rapidly over the coming years, the amendment to recognise palliative care is both necessary and timely. But what does this mean for palliative care services? The Bill aims to reform health care delivery and recognises the need for collaboration, which responds to local population health need. It hopes to promote integration and facilitate collaboration between health and care organisations at a local level. Improved partnership working between specialist palliative care and generalist palliative care should support better communication between services, education opportunities and improved provision of end of life care.

HOW THIS WILL IMPACT ON PEOPLE

The core aim of the Bill amendment is to ensure that the provision of specialist palliative care for local populations is placed high on the agenda of commissioners. To those persons with a life-shortening condition who require specialist support, and their families, this change could mean the difference between achieving a good death or as is often reported now 'a less than satisfactory experience'. For communities who currently are disadvantaged because of a lack of specialist palliative care services in their locality, the proposals have the potential to positively impact on their care.

Timely access to services 24 hours a day across

a seven-day week, which offer expert symptom management and psychosocial support, could improve the quality-of-life for the growing numbers of people who are expected to need these services. It should be recognised that some areas of the country already have excellent specialist palliative care provision with access to hospice care and specialist teams in hospital and community. However, for those areas currently not so well provisioned, this lack of support places extra pressure on the NHS with patients who should be able to access the care they need outside of an acute hospital bed.

IMPACT ON FAMILIES

For the families and carers of people who have a life-shortening illness, the inability to access specialist palliative care locally and at the time they need it can cause an unnecessary additional burden. If the amendments in the Bill are widely adopted across integrated services, then more families and carers will be better informed and supported. Families and carers will also have more choice around the availability of services for their loved ones and be able to access 'around the clock' specialist advice.

Dame Cicely Saunders is highly regarded as the founder of the hospice movement and acknowledged that how a person dies remains in the memory of their families and carers. This supports the need for the availability of specialist palliative care for all who need it. Consideration should also be given to the need for pre- and post-bereavement support – another service that is sporadic across many settings. Whilst many hospices offer the care needed that is highlighted within the amendments to the Bill, not all localities have specialist hospices and, where there are hospices, due to inequalities of commissioned funding, services are at risk of being cut. Hospices have been facing critical funding issues for a prolonged period and are reliant on the financial charitable support of their communities which, in the current challenging economic climate, is not a dependable source of income.

A STEP IN THE RIGHT DIRECTION?

Access to specialist palliative care for those persons that require it should be an integral part of the wider health care system. The changes brought about by this Bill most certainly indicate a move in the right direction. It should not be something that happens by chance dependent upon the locality in which a person lives and the services that are or are not commissioned. The success of the Bill is dependent upon wider system collaboration, equity of funding by commissioners and the development of services.

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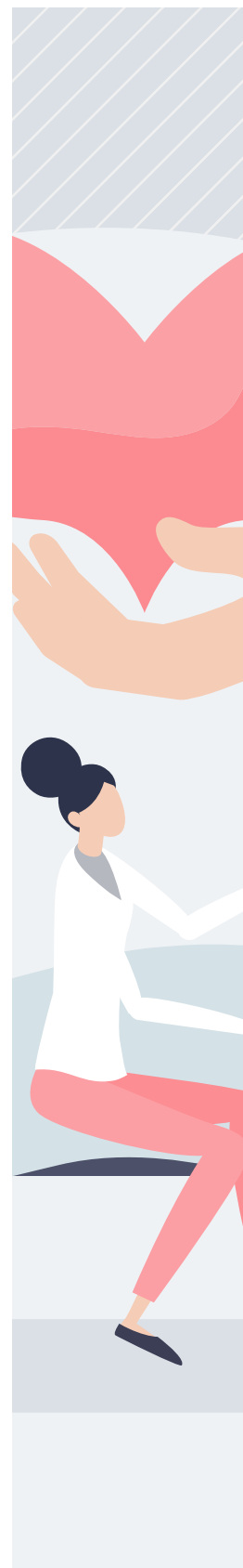
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What do you think needs to happen in your area to improve the availability and delivery of palliative care? Visit www.caremanagementmatters.co.uk and share your feedback on the article.



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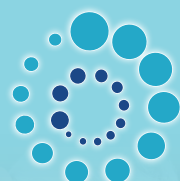
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Cultural snapshot

COVID-19 VACCINE DISTRIBUTION ACROSS THE GLOBE

The COVID-19 pandemic has challenged health and long-term care systems on a global scale. It does not stop at borders. In this article, Emi Kiyota provides an analysis of Global Ageing Network's report on vaccination distribution in elder care.



It is no secret that the COVID-19 pandemic has altered the way we live. The pandemic has brought to light a number of critical challenges in the delivery of care and services. As one example, the deployment of the COVID-19 vaccine highlighted the barriers and disparities among different cultures and age groups, especially among older adults. Older people, especially those living in long-term care settings where infections can spread easily, belong to this high-risk group. The impact of the pandemic and distribution is now under review and investigation in various countries.

COLLATING EVIDENCE

In 2021, the Global Ageing Network, the world's only network of ageing service providers, in partnership with Standards Wise International, embarked on qualitative research in the report, 'The COVID-19 Vaccine Distribution in Elder Care: A cross cultural snapshot', to examine the challenges providers were facing in accessing vaccines and deploying vaccinations. The study focused primarily on residential settings such as nursing homes, group homes and assisted living communities. However, information was also gathered from providers about the vaccine-related experiences of community-dwelling elders who receive home and community-based care.

The research was conducted by Dr Emi Kiyota, an Environmental Gerontologist. In addition to interviews conducted with aged care leaders in 12 countries, Dr Kiyota reviewed published data. Most of the selected providers also participated in a previous study, 'Elder Care Providers & COVID-19: Cross-cultural perspectives'.

KEY FINDINGS

1. Vaccine supplies and vaccination schedules were unreliable. Many of the surveyed providers reported challenges related to shortages of COVID-19 vaccines and frequent changes in vaccination schedules.
2. Strong leadership was critical. Vaccination rates increased when national governments exercised strong leadership in securing vaccines and issuing policies, which prioritised residents of elder care settings for vaccination.
3. Community-dwelling elders faced greater challenges. Elders living in their community, rather than in a congregate setting, had more difficulty obtaining vaccinations than elders living in long-term care settings. Community-dwelling elders had limited access to the help they needed to navigate web-based appointment systems and had more trouble accessing vaccination sites.
4. Rationales behind vaccination priority categories were often unclear and sometimes inconsistent. Several countries excluded elder care workers from the 'health

care worker' category, causing significant delays in staff vaccinations.

5. Preparing residents for vaccination was challenging. Government agencies had difficulty co-ordinating vaccination logistics and often gave last-minute notice about the schedules for vaccination clinics. This created challenges for providers seeking to prepare residents to be vaccinated.
6. Staff vaccinations caused care-related challenges. Worker shortages made it more difficult for staff members to provide sufficient care to residents and clients while also obtaining vaccines or recovering from vaccine side effects. These shortages were particularly problematic when staff members could not obtain vaccinations at work.
7. Staff members were receptive to misinformation. Misinformation and rumours about COVID-19 vaccines, spread mainly through social networks, made it more difficult to reach high vaccine uptake rates among staff members.
8. National health care systems influenced vaccination success. Countries with a national health care system achieved high vaccination uptake at a faster rate than countries without such a system. The COVID-19 vaccination rollout was swiftly co-ordinated in countries like Israel and the United Kingdom, while other countries struggled to acquire enough vaccines and/or to co-ordinate logistics.
9. Inequities were real. Stark inequities emerged between high- and middle-to-low-income countries. Those inequities were particularly evident when comparing the relatively generous amount and variety of vaccines available for distribution in high-income countries, and the shortages of vaccines in lower-income nations.

REPORT THEMES

The report highlighted six major themes. First, all providers that participated in the study had some level of experience with vaccination planning before the pandemic began. However, the plans focused primarily on influenza vaccinations. The COVID-19 rollout proved to be more challenging at a national or regional level and exposed issues around confidentiality, public perceptions and confidence in the efficacy of the vaccines. Countries such as the United Kingdom and Israel, which managed their vaccine rollouts through their national health care systems, were able to co-ordinate vaccine administration through primary doctors.

The second theme that emerged focused on vaccine availability. Regional differences in vaccine availability and other logistics affected vaccine scheduling within countries. Community-dwelling older people were vaccinated later than older adults living in long-term care settings. Hospital



> systems in the United Kingdom and Israel did not rely on community-dwelling elders to make their own vaccine appointments on a computer or by phone, which often involved long waits. Instead, the systems reached out to these individuals by phone to set up their vaccination appointments.

PRIORITY

All 12 countries gave health care workers first priority for vaccination over other workers. Most countries included long-term care workers as part of that first-priority group. In the few countries that did not follow this protocol, including Australia, Mexico and some of the European countries, staff members had to wait until their age group was eligible for vaccination. This delay caused many infection-control and staffing challenges for providers. High-income countries were able to start vaccinations quicker than middle- to low-income countries. Providers in the 12 study countries did not have access to all eight types of vaccines available worldwide. It appears that higher-income countries administered Pfizer, Oxford/AstraZeneca, Moderna, and Johnson and Johnson vaccines, while middle- to lower-income countries used these vaccines but added the Chinese and Russian vaccines when they could not obtain adequate vaccine supplies.

DELIVERY

Third, providers followed the same process for vaccine delivery and administration. All the providers participating in this study assigned either one person or a team to co-ordinate vaccination delivery. Vaccines could only be administered by personnel assigned by the Government, which created challenges in co-ordination, unclear communication, confusion around web-based appointments and logistical challenges. In some countries, such as South Africa, Singapore and the United Kingdom, in-house nurses were allowed to administer vaccinations.

REFUSAL

The fourth theme focused on vaccine acceptance. Vaccine acceptance among residents was high in most of the countries. Vaccine refusals came primarily from family members who had concerns about side effects, the frailty of their relatives, and rumours and misinformation that had been spread through social media. However, the vaccination

acceptance rate was initially lower among staff members, due mainly to fears spurred by misinformation, religious objections and their own existing medical conditions.

In some study countries, including the Netherlands, Spain and the United Kingdom, providers did not know the vaccination status of staff members due to privacy laws. Almost one year after the vaccine rollout started, Australia and Canada made vaccinations mandatory for health care and elder care workers.

COMMUNICATION

Fifth, communication with staff, families and national and local authorities was of upmost importance to address rumours and misinformation about vaccines. The goal of the communication was to inform family members about an organisation's vaccination plans and to obtain informed consent signatures. Many providers conducted in-person meetings and education sessions with staff to explain the safety of vaccines. During the national vaccine rollout, providers communicated regularly with national and local authorities. Many providers reported that their communication with the Government during the infection-control phase of the pandemic made it easy to establish effective communications during the vaccine rollout. The responsibility of providers to send reports to the Government was varied.

Elder care associations played an important role in distributing vaccine-related resources in the Netherlands, the United Kingdom and Spain. However, widespread vaccine misinformation caused the most common communication challenges encountered by providers. Providers had to rebut rumours about the efficacy of different vaccine products, side effects and the rationale behind how groups of staff members were prioritised for the vaccine.

POLICY

The final theme revolved around policy-related challenges. Most providers reported that their governments issued policies and guidelines for vaccinating elders in long-term care settings, but that these policies were not effective for community-dwelling elders who do not reside in those settings. A provider from the United Kingdom discussed the need to make vaccine-related educational materials more sensitive to cultural issues that might affect vaccine acceptance. All 12 countries in the study established priority groups for

vaccinations; however, the rationale behind these priorities was not well communicated to providers or the public. Providers agreed that these criteria should have been presented in a clear and logical manner. As knowledge about COVID-19 evolved, messages from policymakers kept changing. Moreover, multiple layers of Government (federal, state and city) and various disciplines (health, social services and ageing services) were involved in the decision-making and communication about the vaccine rollout. The messages from these entities often conflicted.

LESSONS LEARNT

The report identified six key lessons and associated action items that emerged from the participating providers and stakeholders:

- National governmental leadership was key to an effective COVID-19 vaccine rollout.
- Elders living in long-term care settings were able to access vaccinations more easily than community-dwelling elders, due to the support offered by care settings.
- Staff members in long-term care settings had lower vaccine acceptance rates than elders living in those settings.
- COVID-19 revealed a troubling inequity in vaccine distribution and choice around the globe.
- The COVID-19 vaccine rollout shed light on the ethical tension between personal choice and public health.
- Communications with a designated contact point were key to an effective vaccine rollout.

Almost two years after COVID-19 first appeared in the world, we are still facing challenges related to COVID-19. Providers, policymakers and researchers must now turn their attention to measures that can be put in place to avoid the mistakes of recent months. Providers have a unique perspective that can't be overlooked as they are responsible for the wellbeing of many older adults in a variety of settings. The knowledge and insights that can be gleaned from conversations with an even larger group of providers will be invaluable as the pandemic continues, the status of vaccinations evolves and new variants possibly emerge. In addition, leaders around the world should focus attention on critical issues that emerged, including equity, ethics, mental health and the need for collaboration.

Thank you to the partner of the Global Ageing Network report, Standards Wise International.

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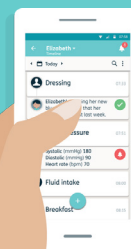


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No time to waste

Making the case for digital systems in the care sector



The Government has set ambitious targets around technology and the care sector, but what does this look like in practice? Jonathan Papworth, of Person Centred Software, outlines the targets and what providers must consider.

We are now familiar with the Department of Health and Social Care's (DHSC) White Paper 'People at the Heart of Care' and the Government's plans on technology and reform. One key area, which is frequently discussed, is digitalising care records.

At Care England's #FacingTheFuture conference, the Health Secretary, Sajid Javid, informed delegates that the Government 'will work with' social care providers to make sure the sector reaches its target of 80% of providers utilising a digitised care record that can connect to a shared care record by March 2024 – currently that figure sits at 40%. ➤



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> HOW TO GET THERE

For three years now, NHSX has been on a mission to drive the digital transformation of the NHS and social care and, according to NHSX, it has got basic shared care records into every Integrated Care System (ICS) except one, enabling health and care staff to view and edit the same version of a person's medical history across health and care settings so that they can collectively deliver safer, more joined up and seamless care.

The Care Quality Commission (CQC) said a good records system delivers good outcomes from the point of view of people who use services. These outcomes are the same whether the records are kept digitally or on paper, although what providers need to do to deliver them might vary. Digital care records are widely recognised as improving quality of care and improving effectiveness of care delivery, as well as being the gateway to sharing data across care settings.

OVERCOMING OBSTACLES

There are three main obstacles that are frequently cited for staying with existing paper-based care systems. Cost, operational interruption and change management. Of these, change management is generally the toughest and biggest obstacle.

Many people cling to existing processes as a kind of security blanket and taking that blanket away needs to be managed very carefully and considerably. Sometimes it takes a change of personnel to remove the security blanket, but this is not a feasible way forward for the majority of care providers, so helping people understand and embrace the opportunities that digital technology provides is a necessary process.

A good digital system will provide massive improvements in operational efficiency, so the trick to minimising the operational interruption is to take the advantage of some efficiencies as early in the process as possible. It is normally best to implement the system in functional steps, rather than try to do everything at once, and it is often best to implement one function across all service users rather than all functions for one service user at a time, because this makes the change least confusing for care staff.

Software companies have basically four costs: sales and marketing (or promoting); service delivery; infrastructure costs (often called hosting costs); and software development costs (or research and development). All of these costs need to be paid either by customers or investors, and if paid by investors then the costs still need to be paid by customers, just future customers. By looking at cost paid for software from the perspective of the company providing the software, it should help to ensure they understand what an appropriate price is to pay. Digital care software is too important to end up with a poor product, and then suffer the need to change later due to poor experience. Negotiate the best price you can, but don't put price above the benefits that better products can provide.

Whilst all this needs due consideration, the benefits realised having moved to an effective digital system far outweigh the short-term pain. There will be an ongoing

cost for a digital system, and, despite recognised improvements in efficiency, this rarely resolves to a reduction in other costs. However, the focus on integration of data, and the financial support now available helps to remove this barrier.

SHARING INFORMATION

Person Centred Software welcomes the White Paper's core objectives. In particular, we welcome the recognition that people live well when they are part of a community – an aspect that is at the heart of our digital care product. Part of this is ensuring as much information as possible is shared between organisations, to help people to feel that their care is connected.

Having recently passed the two-year anniversary of the UK's first official lockdown in response to the coronavirus pandemic, we, as a sector, have come to realise the sharing of information is also necessary to help inform clinical decision making; making the best decisions saves lives. What the pandemic has shown is that, more so than ever, people across health and social care need to share information with those who need it quickly, securely, and efficiently in order that the best decisions can be made, and to provide integrated care for people when they move between services.

The interoperability of data between social care and the NHS in early 2021, for instance, has now really begun to take traction and we hope it continues at pace as we move forward. We believe that the more joined up the different elements of care are, the more likely everyone is to achieve the best outcomes.

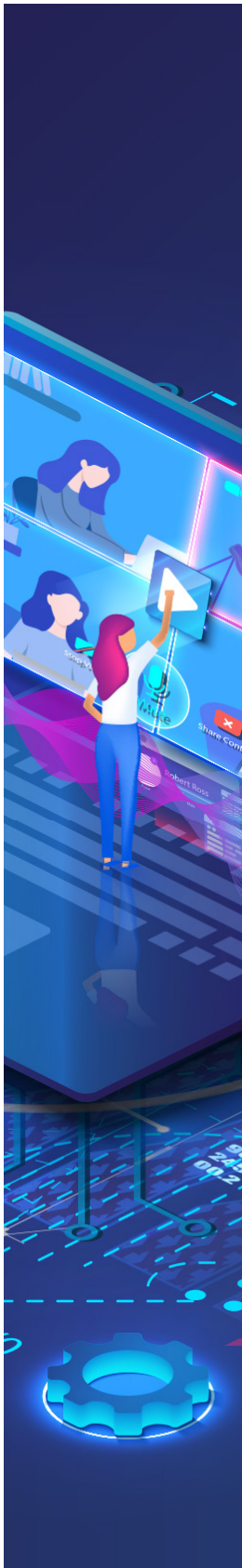
JOINING UP SYSTEMS

In February 2021 we launched our interface to GP Connect that enables care providers to view residents' medical needs in real time, which is particularly useful when transferred from hospital to a care home. To have access to GP Connect, care providers need to show their digital maturity by meeting the standards set by the NHS Data Security and Protection Toolkit (DSPT) but having met these standards they will have access to GP records and medical notes, which enable better informed decisions which leads to better care and improved outcomes.

Just over 12 months from the launch of GP Connect, we have seen the bi-directional software installed in 200 locations across the UK. As at writing, we can now provide access to GP Connect for over 30,000 people – the residents at all homes that are DSPT standards met.

For care providers, the timesaving benefits for staff are exponential, as the system improves their knowledge of the individuals they care for. The type of information that is made available through the digital care management system includes: hospital visits, diagnosis, allergies and adverse reactions, acute and repeat medication, referrals, observations and immunisations.

The systematic switch enables authorised clinical staff to share and view GP records and medical notes quickly and efficiently. In addition, staff are granted access to real-time information and get a clearer picture of historic care for residents. The software >



> also helps health and social care providers to deliver the safest and most effective form of care, while simultaneously improving overall decision making.

Mike Armstrong, Managing Director at Havering Care Homes, signed data-sharing agreements for GP Connect. He told us, 'The key benefits of the integration with GP Connect include our nurses now having access to real-time information as well as a clearer picture of our residents' historic care. The vast amount of time saved by having instantaneous accessibility is beneficial for not only our nurses but for GPs too, as we no longer need to call them for updates or information.'

Ultimately, this should lead to medication being able to be shared between different settings and, as a result, expensive medication will no longer be disposed of when a person goes from a care home to a hospital. The cost to the NHS of wasted medication was estimated in 2015 to be £300m per year, with one of the contributing factors being deliberate discarding between care settings.

The digital transfer of care home hospital packs directly to hospital systems is another benefit of many digital care systems. In 2019, a steering group was brought together to develop a national product as part of the NHS Pathfinders project to design the eRedBag.

The eRedBag enables advanced care plans to be sent to hospitals in advance of the resident arriving by ambulance, giving doctors and consultants notice of the individual's care needs prior to being seen. eRedBag care plans that originated from social care records have been accessed by numerous types of people in the NHS, including nurses, doctors, surgeons and consultants, and have improved the treatment of people undergoing

emergency transfer to hospital simply by sharing the data held by a care provider.

BUILDING THE MOMENTUM

With integration allowing for all-important information to be kept in one place and be easily accessible, we expect interoperability to help continue driving improvements across the industry. Indeed, last year was the start of true two-way interoperability. But the pace necessary for 80% of social care providers to have a digitised care record in place by March 2024 will only be achieved with a significantly increased rate of adoption of technology.

As a software provider, we have always strived to make life better for everyone involved in social care. Delivering interoperability is a step change towards the integration of health and social care, improving information flow as people transition between care settings.

The journey to fully integrate health and social care is well underway, and several care providers are already on board – but the momentum must continue and at quite a rapid pace.

Any care provider that is not already using one of the digital care systems that are working with GP Connect risks being left behind, and in doing so, compromises its ability to provide outstanding quality to the people it cares for.

While we welcome the direction we are slowly moving towards, it must be reiterated that the need for all social care providers to adopt digital care systems is urgent.

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Jonathan Papworth is Founder of Person Centred Software.

Email: hello@personcentredsoftware.com Twitter: [@PersonCentredSW](https://twitter.com/PersonCentredSW)

What types of technology software has your organisation benefited from? And what's your reaction to the Government's target to digitalise care records? Visit www.caremanagementmatters.co.uk and share your feedback on the article.



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CELEBRATING EXCELLENCE IN **END OF LIFE** CARE



In the first of a series of features celebrating 2022's winners, CMM is thrilled to learn more about the recipient of the End of Life Care Award, Jewish Care, from its End of Life and Palliative Care Lead, Paula Plaskow.

Jewish Care was praised by the judges for its dedication to ongoing training opportunities across the organisation. Jewish Care's particular emphasis on reflection post death and focus on what can be learned from each bereavement to improve outcomes for future residents and families struck a chord with the judges. Excellent advanced care planning was also commended.

SHIFTING THE FOCUS

In a crisis situation, health care focus is generally asking about emergency treatments (such as DNAR/CPR – Do Not Attempt Cardiopulmonary Resuscitation or Cardiopulmonary Resuscitation), making conversations stilted, as it focuses on treatments to be avoided rather than concentrating on quality of life remaining.

During 2020, COVID-19 spotlighted the topic of death, forcing individuals and families to talk about dying and decision-making;

something people rarely consider. Advance Care Planning (ACP) enables people to make decisions about their choices and preferences whilst they have mental capacity and record it in various non-legal ways. Because most of us do not volunteer these conversations while we are well, they often take place hurriedly when it may be too late.

Beginning with what matters most to people can help compassionate conversations flow and normalise the importance of regular advance planning as a matter of routine.

RESPECTING PEOPLE, CULTURE AND TRADITION

We encourage individuals we support, both in the community and in our care homes, to have meaningful conversations about end of life with important people in their lives. Jewish Care designed a culturally specific Advance Care Plan, which takes into account Jewish traditions and cultural practices to enable people's choices and preferences to be documented.

Additionally, should people lose mental capacity at any age, temporarily or in the long term, they gain peace of mind knowing that

what is important to them will be considered by giving Health and Welfare Lasting Power of Attorney to people they trust. These people can then advocate with medical and health care practitioners who may need to make decisions about their care and treatment.

“Discussing plans in advance helps people to think about their attitudes to quality of life versus quantity of life.”

Quality of life is not just medical – there’s a whole person to consider. For example, is the person being supported the type of person who wants to know every aspect about their illness and, if not, who would they want to assist them and share the information? Understanding what matters most to someone today, tomorrow and for the future, is about having regular meaningful conversations with important people who need to know, about living life, as well as talking about the end of life.

PROMOTING MEANINGFUL CONVERSATIONS

During COVID-19, staff at our care homes were supported to have discussions with residents and their families about DNAR/CPR, be admitted to hospital and about whether to be admitted, or remain in our care home. People and families in our care homes and the community found themselves unexpectedly taking difficult end of life decisions, co-ordinating burial arrangements and trying to make sense of powerful and overwhelming emotions. Staff can also achieve a greater sense of purpose and fulfilment, knowing they did the best they could to honour and respect a resident’s choices and preferences where possible.

It’s about having regular meaningful conversations about smaller things in life. Listening with compassion, looking for ways to engage with the person and focusing on the things that matter most to them gives them the dignity, respect and a sense of control. Advance Care Planning means you can discuss and plan your future care and treatment. You can also keep a formal record of your wishes. Advance Care Planning is voluntary, and you can change your wishes at any time. If you become unwell and cannot speak for yourself, an Advance Care Plan will help health and

care professionals, and those close to you, to understand your choices and preferences when making decisions about your care.

If the Advance Care Plan cannot be completed by the person due to lack of mental capacity, it can be filled in by someone legally appointed to have Lasting Power of Attorney for their health and welfare. In this situation, the appointed individual must consider what care would have been wanted and what is in the best interests of the person. Discussions with family, carers and others who are close are extremely important and can help.

People are living longer with increasing dementia diagnoses, multiple health conditions and acute frailty. Discussing plans in advance helps people to think about their attitudes to quality of life versus quantity of life.

HELPING FAMILIES TO PLAN FOR END OF LIFE

Too often, families are left with lasting unease, guilt and remorse as the result of unresolved questions and answers. Evidence suggests there is still not sufficient relevance placed on the importance of having early conversations and recording about Advance Care Plan discussions. So, unfortunately, when a crisis or death occurs, family and friends too often do not know what the person wanted.

When choices and preferences are discussed ahead of time, it can prevent people receiving treatment they may not have wanted had their options and views been better understood. We also inform people of available palliative services and how to manage an end of life situation at home, which can often be helpful in preventing an emergency admission.

Jewish Care also works with health and social care teams to be part of a multi-disciplinary conversation, supporting communication and understanding of cultural issues around Jewish burial and mourning traditions.

EMPHASISING COMPASSION AND DIGNITY

We’ve seen that having regular reviews is paramount as a person’s choices and preferences about care may change over time. These regular conversations enable our staff to put in place an Advance Care Plan that emphasises compassion and dignity. It is important for us to capture a person’s choices and preferences alongside their cultural values, helping them to feel heard and respected, providing comfort to family and friends who can help their bereavement journey.

We hope to reduce the number of people experiencing disturbing memories of events leading up to a death and enhance the bereavement journey, helping people to achieve an ending that is dignified and respectful, bringing with it a sense of comfort, satisfaction and peace.

We would like it to become standard practice for staff to look and listen for ways to engage; talk about smaller things and focus on things that matter most to a person. Staff should have regular access to training on Advance Care Planning, End of Life Care, and Palliative Care guidance.

This, along with greater public awareness of the importance of encouraging compassionate Advance Care Plan conversations and education with regular reviews, would help to give more positive experiences at end of life.

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Paula Plaskow is End of Life and Palliative Care Lead at Jewish Care.
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Twitter: [@jewish_care](https://twitter.com/jewish_care)

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

The End of Life Care Award was kindly sponsored by Towergate Insurance.

CMM INSIGHT NORTHAMPTONSHIRE CARE CONFERENCE 2022

25th May 2022

Care Management Matters (CMM) is thrilled to be returning to face-to-face CMM Insight events as we look forward to the upcoming Northamptonshire Care Conference. The Northamptonshire Care Conference, in association with the Northamptonshire Association of Registered Care Homes (NorArch), will take place at the Park Inn by Radisson, Northampton, on 25th May 2022. The conference promises to bring the quality of a national conference to a local stage, focusing on the issues that matter to providers in Northamptonshire.

The day will include presentations from high-level sector representatives, offering expert insight into the local picture, along with an exhibition and a choice of interactive workshops to delve into a subject further. There will also be networking opportunities with like-minded providers and senior decision-makers from the independent care and support sector to learn more about delivering best practice in a changing market.

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A packed agenda awaits delegates attending the Northamptonshire Care Conference. The day's keynote speech will be delivered by Stuart Lackenby, Director of Adult Social Services and Statutory DASS Officer, West Northamptonshire Council. Stuart will be providing an update on the relationship between the council and adult social care providers, how things have developed over the last year and what the plan is for the year ahead. Stuart's keynote speech will also be covering lessons learned from the pandemic which are helping to develop future strategies for the delivery of adult social care in Northamptonshire.

Next up will be Professor Martin Green OBE, Chief Executive, Care England. Martin will be sharing a provider's view of the current adult social care sector and answering key questions such as how can the sector develop in the future and what should it do to become a more outcome-focused, citizen-directed and integrated service? In amongst exhibition viewing and an unmissable panel discussion featuring the conference's speakers, Neil Eastwood, Founder and CEO, Care Friends, will be dissecting the timely subject of care home recruitment. Neil will share the latest thinking, research and innovation, drawing on his connections with employers of care staff from around the world. Every one of Neil's recommendations can be easily implemented

and most cost nothing but have been repeatedly proven to make a big difference.

The conference's afternoon offering will pick up where the morning left off, discussing the sector's hot topics and their application to Northamptonshire's adult social care landscape. Delegates will be joined by Lauren Stacey, Locality Manager (Midlands), Skills for Care, who will be exploring techniques for supporting the workforce. In addition, Jaimini Watson, Service Delivery Manager for Northamptonshire, The Princes Trust, will be rounding off the conference's wealth of sector expertise. Jaimini will explain how the Trust works with young people through a variety of employability programmes and mentoring support to access employment and start their careers in the health and social care sector. The local service delivery team in Northampton will guide delegates through the different ways it can work with employers to recruit more young people and provide feedback from employers and young people on their experiences of working with the Trust.

Book your tickets now and view the conference's full agenda by visiting the CMM website. A discount is available for NorArch and CMM members. Join the conversation on Twitter by tagging @CMM_Magazine and using the hashtag #CMMInsight. Sponsorship and exhibiting opportunities are still available. Visit the CMM website to secure your organisation's place at the Northamptonshire Care Conference.

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Date/Location: 26th April, London
Contact: Web: <https://www.sscr.nihr.ac.uk/event/nihr-sscr-annual-conference-2022/?msclkid=183254e0c24d11ec8ce7ebcbce5322ee>

Event: Wellbeing leadership, what does good look like? Skills for Care
Date/Location: 4th May, **VIRTUAL**
Contact: Web: www.skillsforcare.org.uk/news-and-events/

Event: Creating age-friendly and inclusive homes and communities, Centre for Ageing Better
Date/Location: 12th May, **VIRTUAL**
Contact: Web: <https://ageing-better.org.uk/events/creating-age-friendly-inclusive-homes-communities-tcpa>

Event: Health Plus Care
Date/Location: 18-19th May, ExCeL Centre, London
Contact: Web: www.healthpluscare.co.uk

Event: Integrated care in practice, The King's Fund
Date/Location: 23rd-26th May, **VIRTUAL**
Contact: Web: www.kingsfund.org.uk/events/integrated-care-systems-practice

Event: VODG Annual Conference
Date/Location: 15th June, Birmingham
Contact: Web: <https://www.vodg.org.uk/events/2022-conference/>

Please check with event organisers that conferences have not been cancelled or postponed due to coronavirus before booking or attending.

CMM EVENTS

Event: Northamptonshire Care Conference
Date/Location: 25th May, Northamptonshire
Contact: Care Choices, Tel: 01223 207770

Event: Leeds Care Conference
Date/Location: 30th June, Leeds
Contact: Care Choices, Tel: 01223 207770

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

STRAIGHT TALK

The House of Lords Adult Social Care Select Committee has recently launched an inquiry into the invisibility of adult social care. The committee's Chair, Baroness Andrews, explains how evidence contributed by people has highlighted barriers to reform.



In England, adult social care affects the lives of over 10 million adults at any one time. For most of them, one or more members of the family are also involved in providing unpaid care. The paid social care workforce, for its part, represents another 1.65 million jobs – more than the NHS, construction, transport and the food and drink service industries.

If numbers don't speak loudly enough, there remains the fact that almost every single one of us will draw on the social care system at some point in the future, as new care needs inevitably develop with old age. The importance of adult care is unquestionable. So why is it so invisible?

The House of Lords Adult Social Care Select Committee has just launched a major new inquiry asking that question.

We are focusing on this question because, over the past few weeks, we have listened to colleagues, academics, policy makers and most of all, people with lived experience of the social care system.

The message that came across was not surprising: social care, in most instances, does not work for those who need it. It is notoriously underfunded, but also difficult to access and fragmented. It fails to listen to people and to provide them with a fulfilling life, or to recognise the expertise of those who provide care and support. At times, it appears to be even cruel.

Therefore, we have been prompted to think about the reasons for these shortcomings. Why has successful wide-ranging reform not happened yet? Do these issues receive the attention that they deserve?

In most cases, the answer is no. Despite its immense place within our society, adult social care is not recognised or acknowledged as much as it should be – particularly in comparison with its much better-known sibling, the NHS. The social care system is barely portrayed in the arts and culture; often inaccurately depicted in the mainstream media; and until recently, quasi-absent from the political agenda.

We believe that while the adult social care system remains trapped in invisibility, meaningful reform is impossible. To unlock real change, we will need to transform the way that social care is perceived. Only then will the value of successful reform of the system be understood.

Above all else, this means lifting those who are at the heart of care out of invisibility: the people who draw on care services, but also those who, whether they are family members or friends, provide unpaid care and support.

Too often, we have heard from people with care needs and from carers that they are fighting against a system that does not acknowledge or value their expertise and contribution. They

are not seen as people with aspirations and ambitions, but as a problem to be solved, a burden on society. The services they receive often reflect this deep misunderstanding of who social care is for.

People with care needs and carers are contributors to our society, and they should be valued as such. This means listening to their individual ambitions and aspirations, regardless of their age, condition or personal circumstances, and taking this as a starting point to the care journey – the purpose of which should be to enable people to live an 'ordinary' life; one that they find fulfilling, and in which they are equal citizens.

Many aspects of our social care system are problematic because for too long, the voices of people who draw on care and of carers have been ignored. It should not be expected, for example, that family and friends are always available to provide care for their loved ones; nor should it be assumed that people with care needs want their parents, siblings or friends to become an unpaid carer.

Yet, there is little scope in the current system for people to exercise this degree of choice and control over their own lives. Services have been designed for people to adapt themselves to, rather than the other way around.

In the next few months, our committee will be looking at what needs to change to enable people who draw on adult social care and carers to come first. This will require listening to them, recognising their place and their contributions and lifting them out of invisibility.

Adult social care has always been about the people it is here to serve. While they remain misunderstood and alienated, the system cannot meaningfully deliver. It is time to give a voice to those who are at the heart of care; this is the only way to create a system that truly works, both for those who have care needs and for carers.



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*Maaha Suleiman, 2019 Challenge Runner-up and
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