Response ID ANON-WD5R-5ZMX-P

Submitted to Reform of Adult Social Care Northern Ireland
Submitted on 2022-06-30 21:48:45

Section 75

1 Religious belief

Not Answered

2 Political opinion

Not Answered

3 Racial group

Not Answered

4 Gender

Not Answered

5 Marital status

Not Answered

6 Age bracket

Not Answered

7 Persons with disabilities as defined by the Disability Discrimination Act 1995.

Not Answered

8 Dependants

Not Answered

9 Sexual orientation

Not Answered

About you:

10 Are you responding as an individual or on behalf of an organisation:*Please select as applicable

Academic body

11 If you are responding as an individual, do you live in a rural or urban area?

Not applicable

12 If you are responding on behalf of an organisation, is your organisation:

Urban based

Strategic Priority 1 - Sustainable Systems Building

13 Do you agree with the ethos and direction of travel set out within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

14 Do you agree with the proposed actions within this chapter?

Mostly Agree

Please add any further comments you may have on the proposed actions: (Optional):

This response is provided by Professor Catherine Needham on behalf of the Centre for Care. The Centre is a research-focused collaboration between the Universities of Sheffield, Birmingham, Kent and Oxford, the London School of Hygiene & Tropical Medicine, the Office for National Statistics, Carers UK, the National Children's Bureau and the Social Care Institute for Excellence. Funded by the ESRC (Economic & Social Research Council) as one of its flagship research centres, it works with care sector partners and leading international teams to provide accessible and up-to-date evidence on care – the support needed by people of all ages who need assistance to manage everyday life.

Led at the University of Sheffield by Centre Director Professor Sue Yeandle and Deputy Director Professor Matt Bennett, our work aims to make a positive difference in how care is experienced and provided in the UK and internationally by producing new evidence and thinking for policymakers, care sector organisations and people who need or provide care. Professor Catherine Needham is leading our work on care ecosystems, and has previously led projects on market-shaping and personalisation. Her book on Social Care in the Four Nations of the UK, funded by the ESRC Sustainable Care Programme, will be published in 2023.

Due to the nature of the online portal, we are not able to provide full references for all the points made here. We would be happy to develop any of these points in dialogue with you.

Our response to the specific Power to People proposals is set out below:

Proposal 8: Commissioners and care providers work collaboratively and openly together to develop an agreed true cost of care and a 'sustainable return' for providers.
The move to finding a 'true cost of care' and a sustainable return for providers is a laudable one. Market fragility is a key issue, leading to under-supply in some areas, particularly in rural settings. During our Social Care in the Four Nations research one civil service interviewee from Northern Ireland told us: 'The contract price, particularly for domiciliary care, is low and a lot of providers squeeze their staff in terms of payment of travel time, or travel expenses, mileage. Now, that's less significant if you're able to work by walking to and from a dozen streets, surrounding the street you live in. But if you have to have a car and you have to drive to your clients that becomes an issue.'
The move to a true cost of care approach mirrors current change in England to move to a 'fair cost of care' and a 'market sustainability' approach. However, there are some risks attached to this. Local authorities in England, who are currently exploring what a fair cost of care would be in their area, have expressed concerns that providers may not be willing or able engage in detailed cost consultations at a time when they are highly pressured in delivering their core business. True cost of care calculations based on a median may not be reflective of the range and complexity of provider activities in area. There is also a large amount of uncertainty about the numbers of self-funders who will come forward, potentially overwhelming the capacity of local authorities to deliver assessments. Whilst self-funding rates are much lower in Northern Ireland than in England, they are still around 10 per cent of people in residential care.
It is good to see attention being paid to top up fees within the consultation but in a fragile market there must be attention to the market effects of constraining top ups if these are being used to subsidise inadequate state funding. In England, concerns have been expressed (e.g. by the Nuffield Trust) that inadequate funding for the fair cost of care reforms will lead to more rather than less use of top ups.
https://www.nuffieldtrust.org.uk/resource/fair-cost-of-care-what-is-it-and-will-it-fix-the-problems-in-the-social-care-provider-market

Proposal 9: Where a person can afford to contribute to the cost of a service, they should do so.
Whilst the cost pressures in social care are well set out in the document, it is important to note that this proposal is out of step with the direction of travel in other parts of the UK which are to minimise private liability for care costs. We can see this in the free personal care approach in Scotland, in the care cap in England and in the weekly maximum home care charge in Wales (which is likely to be further reformed to reduce individual liability). We appreciate that this means that people with larger assets are not contributing to domiciliary care – and that this is inconsistent with the charging approach in residential care. However, in the UK we do not means-test health care or education. The most equitable approach to social care is to increase rather than decrease risk pooling, and to make more rather than less of it funded through general taxation. To echo the conclusions of the 1999 Sutherland Inquiry into the long-term funding of social care in the UK:
Long-term care is a risk that is best covered by some kind of risk pooling - to rely on income or savings, as most people effectively have to do now, is not efficient or fair due to the nature of the risk and the size of the sums required.
https://navigator.health.org.uk/theme/respect-old-age-long-term-care-rights-and-responsibilities
It would be a retrograde step for Northern Ireland to increase personal liability for care costs at a time when other UK nations are looking for ways to reduce it.

Proposal 10: HSC Trusts make explicit their commitment to a process for planning the supply of care and support services and which involve all stakeholders early in developing the strategic vision for future provision.
This proposal is welcome. Stakeholders must include people with lived experience, at this strategic level as well as the more operational level set out in proposal 13 below. Despite an increased focus on involvement and co-production in adult social care, much of this is experienced as tokenistic or episodic. Typically, lived experience is not valued as highly as traditional forms of policy analysis and research. However good practice examples do exist for example the Disabled People's Commission run by The London Borough of Hammersmith and Fulham.
https://www.lbhf.gov.uk/councillors-and-democracy/resident-led-commissions/disabled-people-s-commission/nothing-about-disabled-people-without-disabled-pe
In the Centre for Care we work closely with IMPACT (Improving Adult Care Together) Evidence Implementation Centre (co-funded by the Health Foundation and the Economic and Social Research Centre) which is committed to new models of delivering evidence-based improvements in adult social care. These are based on three kinds of knowledge - conventional published research, 'practice wisdom' and 'lived experience'. Work on this is being piloted in 2022, prior to full implementation across the UK in 2023-2027. IMPACT has already established five 'Assemblies' across the UK (including Northern Ireland) to debate and inform its development, and to consult on promising examples of positive ways forward.
https://more.bham.ac.uk/impact/

Proposal 13: DH introduces a whole-systems approach to facilitating joint working between commissioners, health services and care providers which include a clear mechanism for involving people receiving services and carers within all the HSC Trusts.
Taking a more 'whole system' approach is crucial to improving care outcomes. Recognising that care is an ecosystem underpins the work of the Centre for Care. Care shapes, and is shaped by, multiple systems (housing, health, labour market, migration, welfare), social arrangements (culture, norms, values) and policies (eligibility, funding). These factors can lead to fragmentation in how care is provided or experienced, contributing to intersectional

inequalities, and are deeply affected by external shocks (Covid-19, Brexit). Taking a 'whole systems' approach is vital, however it is important to note that this requires more than simply attention to all the different component parts. The care system is a complex adaptive system. This means that outcomes are hard to control, change is episodic, past events shape the system, but change can come from internal feedback loops and external events. These systemic features mean that policy makers cannot pull a lever and expect change to happen. There has to be attention to key dynamics within localities and the ways that this shapes local implementation. It requires system leaders who can collaborate and be experimental, rather than expecting to be able to deliver top-down change.
Complexity and fragmentation are an inevitable part of social care provision, given the multiple different stakeholders, the wide variety of types of support that people require to live a flourishing life, and the intersection of care with other systems such as housing and employment. Approaches to commissioning need to be able to work with this fragmentation and complexity rather than hoping to design it out. From our research on care market shaping we are not convinced that complexity inhibits service improvement. Care is best delivered by a multiplicity of providers and some fragmentation and complexity is inevitable. This need not inhibit quality, or the achievement of outcomes for people who use those services. Indeed, the institutionalised state-run social care systems of the past could be described as 'simple', but they did not facilitate high quality support that enhanced wellbeing. Whilst oversupply of providers can lead to a lack of focus on quality and a race to the bottom in terms and conditions, undersupply and a small number of providers can lead to stifling of innovation and can minimise voice and control of people using services. The key is to train, support and retain commissioners who can work in 'whole system' ways and be comfortable with this complexity.
https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/publications/shifting-shapes-policy-brief.pdf

Proposal 14: The Expert Advisory Panel proposes that the HSC Trusts promote a collaborative, rather than competitive, ethos which fully involves all key stakeholders in the care and support system
This is to be welcomed, although it would be good to see the mechanisms through which this is to be achieved. Our care market shaping research found that limited staff capacity and high staff turnover in commissioning has made it difficult to build good collaborative relationships and sustain trust. What national support can do best is to build the technical and relational capabilities of local commissioners. We suggest that more work is done in localities to bring together care market teams (encompassing procurement/legal staff as well as commissioners) with providers in initiatives to build trust and facilitate opportunities for co-design. This will involve providers being willing to be transparent about their financial models (e.g. open book accounting) and could include the use of new contracting mechanisms. For example alliance contracting provides a way for providers and community organisations to work together rather than in competition.
https://www.kingsfund.org.uk/sites/default/files/media/linda-hutchinson-alliance-contracting-27.03.14_0.pdf

Strategic Priority 2 - A Valued Workforce

15 Do you agree with the ethos and direction of travel set out within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

16 Do you agree with the proposed actions within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

Proposal 1: DH and HSC Trusts promote the positive contribution of adult care and support, working with key stakeholders including the media
Adult social care lacks the visibility and public affection of the NHS, with care work seen as "an extension of domestic work" not a distinct, skilled profession (Laugier, 2021). Research shows many people do not understand the difference between health and social care and often revert to talking about health even when specifically asked about social care. Reasons for this include the complexity of social care funding and the lesser use of, and familiarity with, social care compared to the NHS. https://www.health.org.uk/publications/public-acceptability-of-health-and-social-care-funding-options
Increased public understanding and support for social care will be a key factor in reform. The social movement #socialcarefuture gives an expansive view of what the aims of social care should be, which moves us away from seeing it through a functional lens:
'We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing the things that matter to us.' https://socialcarefuture.blog/
We suggest that a good test for any new proposals is how far they are likely to support people to do this.

Proposal 6: Living wage should be introduced, with a longer-term plan to equalise pay and conditions across the social care workforce.
We support this plan to equalise pay and conditions across the social care workforce. Our research in Northern Ireland as part of the Social Care in the Four Nations project found that pressures on external providers were in part a result of the higher wages paid by the Health and Social Care Trusts. Obviously, higher wages can be a positive development within social care, but some private providers reported feeling trapped in a downward spiral if the rates at which the state commissions services do not allow for higher wages. As we were told in our local site in Northern Ireland:
'The trust terms and conditions are very favourable. There's no question of that. They are favourable. I mean the things like sick leave and pensions, all the terms and conditions that would be appealing...That, again, is a difficulty for the independent sector because they would often tell us that we are taking their staff. And which is probably in many cases right.' (NI, Director of Adult Services).
There is learning from Scotland in relation to introduction of the Scottish Real Living Wage into the care sector. When we asked a civil service interview about this, they noted that it had not eased strains on the workforce:
'I think it's made a difference to [the individual care workers], but it's not generated any more capacity. It's actually reduced the capacity as well, because to be able to afford the living wage they've had to reduce the numbers of people that they employ.' (Scotland, civil servant)
This highlights the importance of linking improved pay to a broader reform strategy for the sector.

Proposal 7: NISCC elevates the status of the care workforce including development of a professional body.
We support the range of initiatives described to improve the status of the care workforce, including values based recruitment and relational training. We

also welcomed the comment in Power to People that we need to get the balance right between regulating and trusting staff. Similarly, the Feeley report, on a National Care Service for Scotland, noted, 'the workforce too often feel policed rather than supported as a consequence of current registration arrangements.' https://www.gov.scot/publications/independent-review-adult-social-care-scotland/
The All Party Parliamentary Group on Adult Social Care produced a 'four nations' report on the professionalization of care workers which may be of interest. https://www.gmb.org.uk/sites/default/files/APPG_SOCIALCARE_REPORT.pdf This report was produced before Covid-19, which has further intensified pressures in the care workforce. Our Centre for Care colleague Professor Shereen Hussein from the London School of Hygiene and Tropical Medicine is leading our work on the care workforce, and has published guidance on how to improve the quality of work for care workers, which includes the Covid-19 context: https://pubmed.ncbi.nlm.nih.gov/35055767/

Strategic Priority 3 - Individual Choice and Control

17 Do you agree with the ethos and direction of travel set out within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

18 Do you agree with the proposed actions within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

Proposal 2: Self Directed Support should be the norm and should stimulate a diverse market of care and support provision as a matter of priority
We very much support the commitment to self-directed support in Power to People and the enhancement of individual choice and control.However trade-offs within care market shaping can lead to a deprioritisation of individual choice and control.. Elsewhere in the UK it is shown that rising demand, constraints on public spending, insufficient staffing, weak consumer power and poor flows of information can steer commissioners towards forms of market shaping which stabilise care markets in their current form rather than prioritising individual choice and control. Interviewees in our care market shaping project drew attention to perceived trade-off between individual choice and market stability, and felt that they don't necessarily have the capacity and skills in market management and foresight planning to address this tension.
Furthermore, our Social Care in the Four Nations research found tensions in the overall 'policy mix' of adult social care reform which gives mixed signals about whether individual choice and control remains an important aspiration. Policy makers in all four nations are calling for greater fluidity, differentiation, informality and coproduction whilst also arguing for standardisation, regulation, formality and risk avoidance. Scotland's proposed National Care Service exemplifies these tensions, although versions of the same issues are evident in all four nations. Individual choice and control requires fluidity and differentiation: an open market of provision, a wide definition of what counts as 'care' services, a tolerance of positive risk taking and a light touch approach to audit. It may not sit comfortably with – for example - the development of integrated care systems with health, which can lead to defining care and support more through a health lens rather than a wellbeing lens. Interviewees in our study expressed concern about the over-dominance of health priorities in integrated systems. For example, an interviewee in a Scottish integration authority (which brings together health and care services) told us that the focus had been on NHS discharge because this was the metric on which they were measured, with the result that there was less emphasis on choice and control or well-being.
Therefore, to advance individual choice and control, and aspirations towards self-directed support, it is important to understand how these initiatives fit with the broader set of reforms proposed. Trade-offs can then be discussed and agreed with stakeholders rather than emerging as unforeseen consequences. For example, individual choice and control might lead to people wanting to employ Personal Assistants without the Access NI checks that are proposed in the consultation.

Strategic Priority 4 - Prevention and Early Intervention

19 Do you agree with the ethos and direction of travel set out within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

20 Do you agree with the proposed actions within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

Proposal 4: Neighbourhood based, preventative and citizen-focused community support models are encouraged and enabled, including a social worker-led Community Navigator role.
The commitment to prevention, early intervention and strengths-based approaches is very welcome. Including a legislative commitment to prevention is an important starting point, although it is useful to reflect on the difficulty English local authorities have had in acting on this duty. Our review of the implementation of a number of Care Act 2014 evaluations – including one on prevention - found that it had been hard to prioritise prevention due to the intense funding constraints facing local authorities. Local authorities had been trialling approaches such as strengths-based models of social work and social care, community capacity building and peer support, targeted use of personal budgets and ways of mobilising the effectiveness of people's family and other networks of personal support. However, given the resource-constrained environment, local authorities were finding it difficult to sustain investment in prevention. A national policy emphasis on addressing delayed transfers of care from NHS services encouraged a focus on providing traditional social care placements rather than exploring preventative alternatives. Reductions in staff headcount had limited the ability of local authorities to embed the cultural changes required for a preventative approach, such as distributed leadership.

https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/publications/implementing-the-care-act-2014.pdf

Strategic Priority 5 - Supporting Carers

21 Do you agree with the ethos and direction of travel set out within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

22 Do you agree with the proposed actions within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

Proposal 3: the Expert Advisory Panel proposes that the rights of family carers are put on a legal footing and that a strategy to bring them into the heart of transformation of adult care and support is adopted
Our analysis of care in the four nations of the UK found that Northern Ireland had not progressed as far as the other nations in passing legislation to support carers. Health and Social Care Trusts in Northern Ireland have a duty to inform carers of their right to an assessment, but (unlike other parts of the UK) no duty to meet needs identified by that assessment. Northern Ireland also lacks a legal definition of a carer (which other UK nations have). Moving forward on legislation for carers is therefore vital. However it is only a first step – despite carers legislation in the other three parts of the UK, support for carers remains patchy and inadequate.

In providing better support for carers it is important to recognise that self-identification can be difficult. Many carers do not recognise their role as 'caring'; this underscores the importance of identification by health professionals and their role in signposting carers to support. A NICE Guideline (NG150) on Carers, published in 2020, offers detailed guidance for local authorities and NHS organisations. If widely used, this would lead to substantial improvements in support for carers. https://www.nice.org.uk/guidance/ng150

This invisibility can have especially negative impacts on Black, Asian, Minority Ethnic and Refugee (BAMER) communities due to cultural assumptions. Insecure migration status is also a barrier to accessing support, at the end of 2021 immigration officers were placed in at least 12 English local authorities, reportedly resulting in people lacking leave to remain deciding not to access services and not getting support they need. Caring for someone in another country is a further layer complication for carers and largely ignored by policy and by employers in the UK and internationally. Carers in this situation need to coordinate caring from afar and to navigate time differences; they are often unable to take the leave they require from paid work to attend to caring duties. Transnational carers are also not routinely included in conversations with service providers about the care their loved one needs.
https://www.sciencedirect.com/science/article/pii/S2666558122000124?via%3Dihub

Recognition of carers by GPs and the wider NHS is vital for joined-up services aimed at supporting carers. This has been known for some time, but while some GPs and NHS services show good awareness of carers and respond proactively, this goal is far from being achieved everywhere. Good practice includes recognising carers and recording this on a patient's notes, consulting carers if the person they care for is in hospital and signposting carers to accessible services. These practices and the support that hospitals and other NHS providers can provide have been found in past research to be crucial.
https://www.sheffield.ac.uk/polopoly_fs/1.546423!/file/New-Approaches-Report.pdf

To increase identification, Carers UK, with whom we have collaborated on many studies, also recommends:
• • A national public health campaign, aimed at increasing awareness, recognition, and support for carers and about care more generally, so that carers can identify themselves and know how to access support and advice.
• • Development of education, information, and training for a range of frontline professionals to increase knowledge and signposting of carers
• • A new duty on the NHS to identify carers, to ensure they are routinely identified and that their health and wellbeing is promoted.
• https://www.carersuk.org/for-professionals/policy/policy-library/missing-out-the-identification-challenge

Strategic Priority 6 - Primacy of Home

23 Do you agree with the ethos and direction of travel set out within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

24 Do you agree with the proposed actions within this chapter?

Mostly Agree

Please add any further comments you may have: (Optional):

Proposal 12 – HSC Trusts are enabled to more effectively discharge market shaping responsibilities to facilitate self-directed support and encourage community based models of intervention alongside formal systems of care and support.
Effective market shaping is a vital element of a sustainable care market. Our research into the discharge of market shaping duties in England (under the Care Act 2014) found:
(1) Some local authorities are drifting between different approaches to market shaping over time, often without purposively choosing one approach over another. High turnover of local authority staff, workforce shortages within providers, short-term austerity and long-term funding uncertainty militate

against a coherent approach.
(2) Market shaping works best when commissioners take a 'low control' approach, rather than specifying the service. Two types of low control strategies were found to be effective: 'open market' models, which free up individuals to purchase their own care, with an emphasis on self-directed support; and 'partnership' models, e.g. for building-based, long-term services, that require local authorities to build relationships and share risk with providers and communities.
(3) Both types of provision are needed in local care markets. Open markets for self-directed support already exist in many areas but are fragile and need active local authority facilitation to work effectively. Partnership models are underdeveloped and need to be built up in an iterative way to grow trust, enable providers, service users, families and communities to adapt, and to facilitate joint working with health and housing.
https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/publications/shifting-shapes.pdf
The research was conducted before Covid-19 but the pandemic has further highlighted the importance of trust and good communication between local authorities and the market.

Proposal 15 –Department of Health and the HSC works more closely with the Department for Communities and NI Housing Executive around future strategies for specialist and supported housing to ensure more effective alignment between housing and social care
The principle of the primacy of home is an important one, fitting with the statement cited earlier from #socialcarefuture that we all want to live in a place we call home.
However, provision of appropriate housing remains poor and will need to be rapidly improved if people are to be able to thrive at home (rather than in residential care). Professor Teppo Kroger's new book on Care Poverty (Springer, 2022) notes that living alone is the most consistent factor in explaining unmet need across a range of countries. It is a major risk factor in unmet personal care needs but also unmet socio-emotional needs. It is vital to ensure therefore that a commitment to 'ageing in place' is also attentive to these risks. https://link.springer.com/book/10.1007/978-3-030-97243-1