Homecare Association

Rebalancing Care and Support Programme

Consultation Response on behalf of the Homecare Association

Consultation Questions – Chapter 1

Question 1.1: Do you think the principles and standards set out in the Code will help to ensure Wales-wide consistency in commissioning processes and practice and reduce duplication and complexity?

Question 1.2 Do you think the standards set out in the Code will help to ensure Wales-wide consistency in commissioning processes and practice and reduce duplication and complexity?

[Taking 1.1 and 1.2 together]

We hope that the principles and standards set out in the Code will promote consistency in commissioning practices. However, the principles explicitly draw on the spirit of the existing Social Services & Well-being (Wales) Act 2014 and many of these principles are already embedded in other existing legislation and policy. This begs the question why they have not already been consistently implemented and what the barriers to consistent implementation are.

The National Office is going to be key in promoting consistency, awareness, training and in enforcing the standards. It is difficult to say in advance how well this will operate. If some of the barriers to consistent implementation are to do with availability of resource, knowledge gaps and/or organisational cultures then although the principles and standards in this Code might provide a starting point, concerted effort and skill will be needed to bring about real change.

In terms of duplication and complexity – consideration needs to be given as to who the process is being simplified for. For example, if the complexity and duplication in the commissioning process is simplified for commissioners in a way that makes the process more complex (or otherwise worse, for example by reducing choice) for people using services and/or providers then that may

not be desirable. In other cases risks associated with the commissioning process are effectively ‘outsourced’ to providers – displacing, but not removing, risk and complexity.

The collaboration principle sets an imperative to share risks, resources and assets, this can sometimes lead to authorities seeking out governance structures that lead to providers becoming responsible for significant risks (such as where one provider is commissioned to manage the subcontracting of work to other, usually smaller, providers) and careful consideration from all parties is required before such ventures are taken forward. While some providers are willing to take on such subcontracting responsibilities, not all providers will want to.

Alliance contracting is another area where displacement of complexity could potentially happen. There is supportive evidence around the use of alliance contracting in support for homeless people, for example – often where the different organisations forming an alliance provide different aspects of a service that a person using services might need (for example, one mental health organisation, one focusing on substance misuse, an emergency housing provider etc). This is often not the case in social care at present, an individual would usually have just one social care provider even though the local authority may contract with a number of providers to provide sufficient services in their locality. There are some situations where homecare providers can and do work together effectively. There are also situations where health and social care organisations work together in multi-disciplinary teams (such as in end of life care). However, this requires strong and trusting relationships between partners and very clear governance structures to manage regulatory and operational risks, and to ensure clarity about roles.

Alliance contracting would require significant collaboration at the bidding stage. It also requires ongoing time spent organising and communicating across the team of providers who are working together as an alliance. Careful consideration would be required as to whether alliance contracting could work for any particular task specified, and providers would most likely need to take advice on the risks implicit in the arrangement. We are concerned that if authorities try to use alliance contracting for regular homecare services that this will add additional complexity and expense for providers and reduce the number of homecare providers who are willing to put forward bids due to the complexity and risks that could be associated with this kind of working.

Lastly, we would recommend that the Framework is altered so that as well as Commissioners being required to confirm their fee rates in a timely manner, that Local Authorities and the NHS are required to pay providers for their work in a timely manner. Late payments impact on a business’s cashflow which can be critical for small to medium size enterprises. (This is an area we are

currently working on and will publish some survey findings on late payments in England in the near future).

Question 1.3: Do you think the requirements in relation to Welsh Language will help to bring about consistency around the provision of Welsh language services and the active offer?

Independent sector providers continue to struggle to recruit staff with Welsh Language skills. International recruits (which the sector is having to rely on more due to staff shortages) in particular are not likely to have Welsh Language skills when they begin their employment.

Training staff to speak Welsh is expensive – even if Welsh Language courses are free, paying staff time spent learning Welsh and rewarding progress in Welsh for care staff comes at a cost. We don't believe that these costs are currently being fully met by commissioners of care.

Social Care Wales are providing a free Welsh course which is 60 hours long and covers basic Welsh language. In 2022 there were 19,571 homecare workers with significant waits for services and shortage in capacity in some areas due to lack of staff. If 70% of these (the proportion who currently don't have any Welsh) had to study Welsh for 60 hours that would most likely remove 1.2 million hours of availability to deliver homecare across Wales (over whatever time period that training took place) and cost the sector £33m (given they would need to be paid for work related training and this be treated as part of their working day – our minimum price currently stands at £28.64 per hour).

A more ambitious goal of getting some staff up to a working level of Welsh (B1 or higher, for example) would take around 360 hours per staff member required to undertake this and would be accompanied by further need for capacity and funding (costing over £10,000 per staff member).

Given high turnover rates, there are often a lot of new starters in the workforce – so ongoing training requirements in Welsh are likely to also be high (i.e. it wouldn't be a one-off exercise or a one-off cost to get the workforce language skills up).

Have the Welsh Government fully considered how to fund this or obtain the necessary additional capacity to allow for this within the working day? What support is there for employers to achieve this?

The consultation says:

> "It is recognised that it can be challenging for some providers to meet the active offer however, commissioners and service providers **must** encourage the workforce to communicate in Welsh whatever their level

of Welsh may be, and encourage the workforce to develop their Welsh language skills."

More than encouragement is needed to deliver consistency.

Question 1.4: Do you think the requirements in relation to Equalities will help to promote and improve the rights of individuals receiving care and support and carers?

Potentially. At least some of the actions by local authorities and others that result in unequal treatment will be due to lack of awareness.

Part of what could make such provisions/requirements effective is:
a) training/awareness raising with commissioners (and possibly other) leaders in the sector
b) sharing of learning on inclusion across the sector
c) if people receiving care and support and their carers are aware of the requirements and can reference them when raising concerns.

We will be interested to see what the contract clauses will be, from a provider perspective.

Question 1.5: Do you think the statutory requirements and guidance in the Code will help to reduce complexity and bring about national consistency in the commissioning of care and support?

As outlined above in our answer to 1.1 and 1.2, this really depends on how it is implemented and how the National Office holds commissioners and regional/local leaders to account. Consistency is likely to require enforcement, training and sharing of best practice as well as some pro-forma material, templates etc. We are concerned that Alliance Contracting might just shift complexity onto providers rather than reducing complexity if used in certain contexts.

Question 1.6: Do you think the statutory requirements and guidance in the Code will help to improve outcomes for individuals receiving care and support and carers?

Similarly to what we have said above, the requirements and guidance in the Code should strengthen the case for a move towards outcomes based commissioning and away from time and task commissioning. This is desperately needed and has been tried in some parts of Wales.

However, arguably there was already legislative imperative to do that in the 2014 Act and this has not been acted on. So there are reasons to ask whether the statutory requirements in the Code are sufficient to shift the organisational cultures, funding structures, training requirements and other barriers to

developing these alternative models of commissioning. If the Code is combined with determined leadership from the National Office, the two together would certainly have greater potential for change compared to the current arrangements. We are pleased to see this developing in the right direction.

Question 1.7: Do you think the statutory requirements and guidance in the Code will help to refocus the fundamentals of the care market away from price towards a value measure based upon service quality and overall cost?

Whilst Standard 5 is fairly clear that measurement of value must include outcomes, arguably this has been implicit in the Social Services and Well-being (Wales) Act 2014 for some time already. There are barriers to this having been implemented including budgetary pressures, organisational cultures and lack of understanding of what an alternative might look like and what the cost implications of that alternative might be.

As above, the statutory requirements can reinforce the message that value should be based upon service quality and overall cost. The change will also require leadership (perhaps from the National Office) if it is going to take effect.

We are pleased to see the principle of value over price is being taken forward. Ensuring price is sufficient is also important. We welcome the inclusion of Standard 8. We hope that this will see a considerable change in commissioning behaviour – as we have previously illustrated, we believe 85% of commissioners in Wales are paying rates that do not cover necessary and reasonable delivery costs. However, it is likely that this will also require further funding from the Welsh Government in order for local authorities to meet costs.

Question 1.8: Do you think the statutory requirements and guidance in the Code will help to facilitate the provision of a seamless health and social care service, reducing barriers to joint planning and delivery.

To truly achieve seamless health and social care services we would ideally need a social care system that guaranteed a level of care to people with certain needs, was demand led and free at point of delivery. Financial incentives and levers need to be aligned to support a seamless service across social care, pharmacy, hospitals and GPs – and the strategic targets and goals of these organisations need to harmonise. An effective workforce plan would ensure that there were sufficient staff to deliver the service. Digital transformation is required to have joint health and social care records which provide the right information to the right professionals, and relevant parts of which are also available to the person whose records they are. Further work

on infrastructure (such as mobile network availability); software specifications, interoperability etc. is required to achieve this.

At the moment significant delays can be caused in disputes over funding and financial assessments. Even where funding is available and need is clear care may not be available due to workforce shortages. We understand that some of these issues are under consideration in the National Care Service discussions and the work of the Social Care Fair Work Forum. The Code itself will not be sufficient to achieve these kinds of changes.

It is possible that clauses telling Local Authorities and Health Boards that they must, where it is appropriate to do so, collaborate and jointly commission care and support services might to some extent promote joint working in RPBs. However, it doesn't necessarily identify or address the barriers that there are to joint working under current arrangements. It is important, however, that there is clear accountability where joint commissioning is used – this could be made clearer in the Code.

Whilst this is critically important, seamless health and social care services are also about the training and attitudes of health and social care professionals when working together (for example, on hospital discharge or on getting someone their medication). Organisational culture and organisational structure need to support joint working. There needs to be national strategic alignment in the workforce strategies across health and social care (something we return to in section 2 of the consultation). Social care services need to be included in discussions about peoples care (including in multi-disciplinary teams), and there should be expectations that services are able to contribute as trusted professionals – often being the people who see the person in question the most. Sometimes we find that health colleagues do not recognise the knowledge or skills that careworkers have and can be dismissive of input from social care. Some of this goes beyond the scope of a Commissioning Framework, however, commissioning needs to take account of the fact that true joint working would require time input and skill development to allow for joint working (with attendant costs).

The document also says that "a separate brokerage role could be minimised or in some cases eradicated through the development of multi-professional working; particularly where domiciliary care teams are included as a key element of place-based community resource teams." This may be a step in the right direction. Perhaps the National Office could take steps in the direction of promoting the cultural change to make this a reality. It is important that the expertise of social care colleagues about needs assessment and how to meet needs are recognised and that decisions about care are made via discussion between the commissioner, provider and person receiving support and not just by health colleagues.

Homecare providers are sometimes able to take on delegated healthcare tasks – reducing the number of people needing to visit a person and providing a greater integration of health and social care services. However, these must

be accompanied by appropriate training, signing off of competencies, and funding to reward higher skill levels and undertake more complex tasks. It is important that healthcare professionals understand how homecare is organised and consult with service managers about any tasks to be delegated, rather than delegating directly to careworkers.

Increased use of data visualisation tools and other technology solutions to connect demand supply could be helpful. Many brokerage teams phone around, which is time-consuming and inefficient.

One thing that the Code does mention that should support seamless working is focus on outcomes (as in Standard 5), though possibly it could be clearer that focus on outcomes should be instead of focusing on process or task when commissioning.

Consultation Questions- Chapter 2

Question 2.1 The principle of the pay and progression framework is to offer a national framework that can support the principles of fair work. Do you believe it can support that ambition and the benefits outlined above?

We are keen to see the true value of care work recognised and for there to be clear paths of progression within the sector. However, we do have some concerns about the framework's ability to deliver the benefits outlined in its current form.

Firstly, it is clear that, in order for the framework to be meaningful, employees who advance to higher skill levels need to be paid higher rates in order to reward their skill development and experience. The framework document indicates that a pay structure/ranges will be included at a later stage. The funding of these is absolutely critical.

To cover Real Living Wage in Wales in 2022/23 and meet all of the statutory requirements for operating a business we believe that fee rates of £28.64 would be needed – from what we have heard we believe average rates are significantly below this (we will be publishing evidence regarding this later in the autumn). We do not believe that current fee rates paid by commissioners adequately meet the costs of provision. Without funding to back it, talk of career progression may sound hollow to front line staff and their managers who are struggling under current circumstances.

When calculating the funding increase that is required it must be recognised that pay rates also affect pension, on-costs and other aspects which need to

be properly calculated. We have a Wales specific minimum price for care; and have also worked with the National Commissioning Board on costing models for domiciliary care. We urge the Welsh Government to consider all of the cost elements when determining how much funding is required – it is not sufficient to just consider basic pay increase.

Secondly, we would like to see people being able to move between homecare, care home and health sector work. Currently, the registration route for Social Care Wales is separate for homecare and care homes – should this be the case? Will the framework be aligned with NHS job bands? For a truly integrated workforce, consideration needs to be given as to how this framework and NHS job roles align.

Thirdly, the framework says that “expectations of terms and conditions of employment will also be included to provide guidance to employers”. This raises two concerns. One, that employers may compete with each other through varying what they offer staff based on alterations to terms and conditions (and to some level, a diversity of offering of terms and conditions may be of benefit to prospective employees). Employers may still want to be able to have sufficient flexibility in order to maintain terms and conditions that work for them and for their staff. Secondly, the way that work is organised in residential care settings and homecare settings is very different, as is the way in which care is commissioned and paid for. Any framework that sets out expectations of terms and conditions must take into account a) the differences between homecare and residential care and b) the (often significant and unfunded) costs that are implicit in changing terms and conditions. For example, in order for an employer to be able to employ staff on regular shifts in homecare, this would require commissioners to purchase care in a way that allowed providers to pay staff for downtime between calls if things are unusually quiet or at times of day where there is lower demand or, alternatively, to find alternative work for them to do (respite provision, for example?) at these times. Currently where work is commissioned by the hour at very low rates and often around peak times (morning, evening and meal times, for example) it is difficult to then employ staff on regular shifts. If these changes are not both funded and also backed by matching commissioning practices, then issuing a framework as ‘guidance to employers’ may only increase tension in the sector between employees, employers and funders by setting unrealistic expectations. Peaks and troughs could be minimised through more creative commissioning. One example would be to train homecare staff to do more delegated healthcare tasks - then they could support District Nurses in the "trough" times, smoothing out the hours worked, and making it easier to offer guaranteed hour contracts or contracts for shifts.

Fourthly, continued flexibility in what level to band a job at and what pay rate to offer needs to be available to employers. Some care roles are very bespoke to meet the needs of a specific individual and may mean that careworkers working with that individual need more advanced skills in one or two very specific areas. This can mean some staff will have some specialist skills without becoming a professional practitioner. Employers need appropriate discretion about how to band and renumerate these roles in order to retain staff and ensure that the correct skills are available for the people that they are supporting.

Fifthly, there are complex questions around parity. Social care staff should have parity of treatment and esteem with NHS staff. The Framework document says that the intention is to analyse the current pay and reward systems used by providers and identify clusters and anomalies – this would be internal to the social care sector. It may also be shaped by what commissioners can afford to pay rather than the sustainable costs of delivery (given this shapes existing pricing). As mentioned, we have evidence that (in 2021) 85% of commissioners in Wales paid less than the minimum required to sustainably meet statutory expectations.

It's not clear how the framework will relate to NHS or local authority pay scales (although the Code of Practice suggests that parity might be the policy goal). There needs to be both recognition of the fact that there will be costs and other changes involved if pay and terms and conditions in the independent sector are going to be brought in line with public sector pay and terms and conditions. Clear communication is needed about what the pathway towards greater parity might be and how to achieve that.

Some providers structure their pay differently to how public sector pay scales usually operate, for example, with a stronger focus on performance. There are questions about how and whether a system that aims for parity of treatment would have flexibility to allow for that.

Lastly, whilst this framework can easily apply to regulated care services, it is less clear how it will apply to PAs and microcarers. As Welsh Government colleagues are aware, there are growing concerns about the active encouragement of using micro-providers. If the workforce becomes fragmented into self-employed micro-units it will be harder for those people to be supported with training or mentoring or to achieve career progression. It is likely that many people working as micro-providers would need to move into larger organisations to move up the career ladder.

There may also be other developing roles, such as care technologist, which will become more prominent in the sector and may need to be incorporated into any framework as things develop.

Question 2.2 Do you have any suggestions about how the framework might be improved to help meet its ambitions?

We would like to see the framework recognise the vital role that care co-ordinators contribute to homecare provision. Their role is extremely difficult and logistically challenging, whilst also involving liaising with people who are being supported, their families, staff, managers and commissioners. Whilst the framework has said that it is “limited, initially, to workers providing direct care” (p.2) it then goes on to include social care managers. If social care managers are included, arguably care coordinators should be to as they have just as much contact with staff and the people who are being supported. Many care co-ordinators do deliver some care as well as organising calls.

We would also like to emphasise that the qualities that make someone an excellent careworker often come through values, experience and the development of so called ‘soft skills’. Careworkers need to be emotionally intelligent, handle complex relationships with the people that they support and their family members – often as they go through extremely difficult circumstances and life changes, including end of life care (for which they themselves need emotional resilience). They need to approach their work with an attitude that will empower and respect the person that they are supporting and leave them feeling enabled and build their confidence (and not that care work is being ‘done to’ them). They need to think on their feet, be confident working by themselves and make sensible decisions – staying calm under pressure. They need to handle sensitive topics and information. They need to communicate well with people who may have communication difficulties. They need to be patient, caring, kind and have a sense of humor. Progression in the care workforce also needs to recognise these skills, values, attitudes and behaviors alongside more formulaic training like lifting and handling or medications management.

Whilst some of these attributes are hinted at in the “Values and attributes” section, it does not fully recognise the breadth of skill that is involved here. It also doesn’t really allow for careworkers who excel at these skills to be rewarded.

Some careworkers will also need language skills. We have already discussed Welsh – Polish and Arabic are the next most common languages spoken according to the 2021 Census. Some of those receiving care and support will also communicate using BSL, Makaton or other visual communication or sign languages.

Question 2.3 What may be the barriers to the framework achieving its ambitions?

The primary barriers are those we outlined in response to Question 2.1. There is a need for sufficient **funding** to support any desired change in pay, terms and conditions (particularly in the homecare sector where current local authority **commissioning practices** are geared towards provision based on zero or guaranteed hours arrangements).

There also needs to be sufficient **flexibility** in the model to recognise the range and complexity of roles that exist, with some people specialising in certain skills relevant to specific individuals they work with. Employers may also require a degree of flexibility to allow them to offer a reasonably diverse employment market and incentives for certain employees to continue to work for them.

There are also wider challenges to improving recruitment and retention which are related to cultural attitudes towards care and support that need addressing in broader ways.

Consultation Questions- Chapter 3

Question 3.1: Do you agree with the design for the National Office? If not, what design would you suggest?

We are broadly in agreement with the National Office. We would like to see a greater degree of consistency in commissioning behaviour and collation of national information on social care. We have doubts whether the National Office structure as proposed will have sufficient powers to adequately promote compliance and consistency amongst local authorities. Bodies which have had 'co-ordination' functions previously, like the National Commissioning Board, for example, have had a positive impact but have not produced consistency in key areas (e.g. paying sustainable fee rates to providers). Consideration could be given as to whether the National Office needed legal status in order to have enforcement powers.

Question 3.2: Do you agree with the vision for the National Office? If not, what vision would you suggest?

The vision section of the document obviously links the National Office to a number of other key policy and strategy workstreams within the Welsh Government, rightly so. However, we wonder whether there should be a stronger (and more up-front) emphasis in the vision on the principles enshrined in the core social care legislation such as the Social Services and Well-being (Wales) Act 2014 – this is mentioned a little way down the document. We would suggest that wider links to, for example, the Wellbeing of Future Generations (Wales) Act 2015 are organised afterwards and in relation to the core social care responsibilities.

Question 3.3: Do you agree with the proposed functions for the National Office, and the relationship described with key statutory organisations, particularly local authorities, Social Care Wales, and NHS Wales? If not, what functions do you disagree with and why?

We would like to see some forum like the National Commissioning Board – where commissioners, providers and other key parties can enter into dialogue – maintained in some form. We understand this is under consideration and would be happy to discuss this in more detail.

In a more general context we have had some questions asked about whether Social Care Wales's remit to be both regulator and to promote staff wellbeing, undertake surveys and research and so on is too broad. However, it isn't clear that the National Office would be a better place for any of those functions.

As mentioned in 3.1 we wonder whether the 'enforcement' powers the National Office will have as currently described will be effective, given their legal standing.

Question 3.4: From the proposed functions of the National Office, do you envisage any duplications of work already carried out by other national bodies or organisations and are there further opportunities here for simplification?

Based on what is available it is difficult to tell for sure.

Our primary concern would be a duplication of effort with local authorities – in a best case scenario the National Office would create greater consistency by providing national guidance, tools, templates and so on that could be used by local authorities and NHS commissioners across the country. However, it is possible some local authorities may duplicate, adapt or redesign materials from the National Office creating additional work.

There is an existing policy function within the Welsh Government – we presume that this would move into the National Office?

There is some work undertaken on continuous improvement in relation to social care in Wales already by Improvement Cymru – how would the improvement work of the National Office relate to this?

There is also work being undertaken on improving data in Social Care Wales and around the National Data Resource as well as in other areas so we would not like to see this being duplicated.

Question 3.4a: If yes, how do you propose this is resolved? For instance, would you support certain functions being absorbed by the National Office?

It would seem to make sense for the National Office to lead on Social Care data, policy and improvement in the abstract. However, we recognise that in practice decisions might relate to the location of certain skills, resources, data

sets and so on which may mean joint working is a better option in some cases. Roles need to be clear to prevent duplication of effort and wasted resources.

Question 3.5: In its positioning within the Welsh Government and providing for a 'bird's eye view' of the social care system, what are the main opportunities, working with local authorities, Social Care Wales, and other key partners, to drive service change and improvement? Please give reasons for your answer.

Some key priorities from a homecare provider perspective might be:

1. To support the delivery of outcomes based models of commissioning that move away from time and task and offer a more trusting, collaborative and effective way of providers and commissioners working together around the person. We believe that there are examples of this happening in the Vale of Glamorgan and Gwynedd, which you will be aware of. Moving to outcomes focused practice will require a cultural change and this needs leadership. Whilst there were efforts to lead change ahead of the pandemic, these were disrupted by urgent priorities during the pandemic. A National Office could be well placed to pick up this work and amplify it now. Time and task commissioning in domiciliary care is restrictive and does not support the sector to support people's optimal wellbeing. It may also require more variable working patterns.

2. Finding ways to effectively combine in-person care with technological solutions. This has the potential to provide more enabling, enhanced and safer care whilst making the most of the human value of in person contact. Assistive technology and voluntary sector involvement can also help to delay and reduce need for health and care services by enabling people, meeting basic needs and addressing health risk factors like loneliness.

3. To have a better understanding of the dynamics of the market as a whole. Policy decisions (such as whether to promote micro-care provision, for example) influence the stability and make-up of the whole of the social care market. Whilst RPBs are now required to produce Market Stability reports we would suggest that a National Office would be well placed to develop a better understanding of market dynamics and to advise on policy and promote good practice to commissioners.

4. Using a national costing model to ensure that commissioners are paying care providers sustainable rates that cover the reasonable costs of operating. Whilst a national costing model has been produced by the National Commissioning Board before this is usually not implemented – probably largely because there is insufficient funding and/or concerns that the model was put together by providers. A National Office could check the credibility of the figures, enter into funding discussions with the Welsh Government and encourage compliance in a stronger way than any of the current actors in the sector.

Question 3.6: What do you see as the specific opportunities for the National Office to lead culture change in relation to Welsh language? In particular, the 'More than just words' five-year plan (2022-27).

See our response to Question 1.3 regarding the difficulties in relation to staff capacity and costs of training staff to speak Welsh, and difficulties recruiting staff who already speak Welsh.

Question 3.7: What practical steps can the National Office take to ensure equality of opportunity through social care? Noting the diversity of Wales' communities and people's own circumstances, how can it add value at a national level to ensure people's wellbeing outcomes are consistently met?

Some areas of consideration could be:

- Ensuring that people have access to the care and support that they need and have a choice of where to receive it (for example, not just discharging people from hospital into care homes to free up capacity if this is not the right care option for them).
- Advocating for better working with the NHS. Sometimes specialist and hospital care is needed for people with mental health conditions, dementia, learning disabilities or complex needs. In some cases NHS services are not well equipped to support people with complex needs – even when they are in hospital. Social care services that know individuals and their needs well can be extremely important here (and can sometimes go into hospitals to continue support) but there needs to be recognition from NHS services about the importance and value of social care support, including in healthcare settings.
- Equality of opportunity for people working in care – at present there are aspects of the training requirements (such as the need to complete a Level 2 qualification) which may put off people who want to work on a more casual basis (who are often older, people with care responsibilities or disabilities) in the sector. Could there be a lower tier of registration where people can undertake a more basic level of training and be allowed to undertake more basic care tasks?
- Recognising the value of being able to provide complex care and end of life care in people's own homes.
- Digital inclusion, this is becoming increasingly important for individuals being supported. It is also important to have good coverage, access and resilience as more and more social care records become digital and are shared across health and social services. The National Office could be involved in discussions about issues like internet signal coverage, digital skills for the workforce, data security/disaster recovery and interoperability between different social care, healthcare, pharmacy etc. systems.

Consultation questions – Chapter 4

Question 4.1: Do you have any comments on the detail of the revised draft Code, including any suggestions about what is missing, what could be omitted or where wording could be improved?

Given the research the Welsh Government has underway on micro-care we wonder whether micro-care should be referenced in paragraph 213 as an example of something that should be promoted – this effectively promotes unregulated services. We also believe it is in the public interest for delivery of all personal care and healthcare services, as defined in the legislation, to be regulated, regardless of a careworker's employment status.

We would prefer the use of the term "homecare" than "domiciliary care".

Paragraph 36 – consider the wording of: "identify the range and level of services required to meet and prevent the care and support needs of the population".

Question 4.2: In particular, do the revisions to Chapter 4 help clarify the duty on local authorities to promote social enterprises, co-operatives, user-led services and the third sector? Is anything missing or unclear?

While we understand that this is not a new direction for Welsh Government policy, we believe that care should be commissioned on the quality of the service provided and focused on outcomes.

We are concerned that the focus on delivering via social enterprises, co-operatives and user-led services could, if messaging is not carefully considered, portray privately owned care providers (which may be small family businesses, for example) as being undesirable and possibly even morally compromised. This could understandably be disheartening to some leaders in the sector who have put their hearts and souls into their work and are passionate about what they do.

If the diversity of provision is going to be maintained, it is important that public sector commissioners also consider commissioning private sector provision in creative and outcome focused ways; building on the skills and passion for the work already available in the sector.

It may be discouraging for those considering investing in a homecare start-up or existing homecare business if they feel that there is likely to be increasingly less work available for them should opportunities to provide via third sector provision or in-house, for example, arise.

The Code of Practice as drafted goes further than focusing on social enterprises, co-operatives, user led services and the third sector.

Paragraph 213 also promotes the development of in house services and delivery models such as micro-care provision. There are currently significant concerns that micro-care provision is unregulated and is effectively undercutting regulated homecare services, affecting the ability of homecare providers to secure sufficient work and staff to continue to operate. At the same time we are seeing an increased complexity of need with providers being asked to undertake more complex hospital discharge (which could involve reablement or end of life care), PEG feeds, complex catheter care and other care requirements which are delegated healthcare tasks. There should be mandatory training requirements in place for people undertaking this kind of work and it is unclear how it could be regulated adequately within micro-provision. We would urge the Welsh Government to carefully consider the way that promoting micro-care provision could shape the market and impact the availability of regulated care.

Homecare costs more to deliver due to regulatory requirements and office costs but offers a range of things that microcare or PAs can't offer including: a regulated service with quality standards monitored, sickness absence cover when a careworker is unwell, skills in assessing needs and risks, developed relationships with healthcare and other professionals in the area, office staff for careworkers to call for support or advice if difficult situations arise when working alone, additional training, supervision and support for staff, performance management when things don't go so well and much more. Policies that prioritise on microcare arguably look at price without considering these other aspects.

Question 4.3: Does the new Chapter 5 give the right messages about the duty on local authorities to promote the involvement of service users and carers? Is anything missing or unclear?

It is absolutely vital to involve people in the design of their care and delivery of their personal outcomes. There is already discussion and work within the sector around co-production and outcomes focus so existing knowledge can be built on and shared regarding how best to include people. Having a trusting and collaborative approach to working with providers can assist with this.

Consultation Questions- Chapter 5

Question 5.1: Do you agree with our proposals to amend the Partnership Arrangements Regulations 2015, and to the Care and Support (Area Planning) (Wales) Regulations 2017? Are there any other amendments you feel we need to make?

In England the Care Provider Alliance worked with the Department of Health and Social Care to produce:

Adult social care principles for integrated care partnerships - GOV.UK (www.gov.uk)

This outlines the ways in which Integrated Care Partnerships in England should work together with local Adult Social Care providers.

In practice, there are representatives from Adult Social Care providers on all of the RPBs. However, we would like to highlight the importance of ensuring that the value of adult social care providers as trusted partners in Regional Partnership Boards and the diversity of the sector is fully recognised. This includes ensuring that the voices of people who fund their own care, and the providers who work with them are taken into account when making significant strategic decisions about the sector.

Question 5.2: Have you any comments on the proposed revisions to the Part 9 Statutory Guidance, including any suggestions about what is missing, what could be omitted or where wording could be improved?

There is a significant risk that RPBs tend to focus on the needs of the statutory partners, and for this reason the inclusion of the voluntary sector and Citizen's Voice Body is to be welcomed. However, it is important that their presence is welcomed and that they are fully listened to and are able not only to comment on decisions but also to contribute to and challenge what is on the agenda.

Whilst the motivation behind increasing self-assessment and reporting requirements is understandable and well-intended, there is some concern that the paperwork/reporting burden on RPBs could become substantial and any reporting or self-assessment should ideally be as light-touch as possible to be effective.

More flexibility in pooled budgets and their use for domiciliary care is to be welcomed.

Question 5.3: Do you agree that the proposed amendments to the regulations and statutory guidance will help to strengthen regional partnership arrangements and the role of Regional Partnership Boards? Do you have any other suggestions about what could be included?

Potentially, though the strength of RPBs will really be based on the quality of the relationships of all involved and whether they truly see the challenges that are being faced as shared problems that require teamwork, or if they stick to their own institutional issues.

As above, we would like to see adult social care providers fully included as trusted partners who are able to bring suggestions to the table either on their own behalf or with support from others, (the National Office, for example).

Consultation Questions- Chapter 6

Question 6.1: Are there any barriers in implementing the new guidance for the production of the Local Authority Social Services Annual Reports?

Colleagues in Local Authorities are probably best placed to answer this question.

Question 6.2: What support/training is required in implementing the new guidance?

Local authorities would be best placed to comment on the training of their staff in complying with the new guidance. We note that DASS's could consider undertaking shadowing of frontline care staff in preparation for the development of their reports.

Question 6.3: What outputs or analysis of the Local Authority Social Services Annual Reports would you want to see undertaken?

We would like to see sharing of best practice. We would like to see whether there are regional or national themes in the feedback from people who use care and support services and their families (which could be via the complaints section, but could be wider than that); and also feedback from providers of care and support and other partners.

It would be helpful if the annual reports included the Director of Adult Social Services' assessment of the real cost of delivering care (if this differed from national estimates produced, for example, by the National Office) and whether the commissioning rates paid are covering this. We would like to see this information collated at a national level.

Question 6.4: Do you consider that the combination of the Performance and Improvement Framework, National Outcomes Framework and Local Authority Social Services Annual Reports provides sufficient guidance and structure for local authorities in achieving the outcomes?

The National Framework for Commissioning is mentioned in para 3.1 of the guidance – should this also be given more emphasis in the rationale for this piece of work? The means of commissioning outcomes is arguably as important to the success of those outcomes as the results considered on their own.

"The annual report should reflect the experiences of service providers and service users." Para 87. We would be keen to see this involve both service providers who regularly work with the local authority and others in the area (who, for example, may have bid for work and not been awarded it, or who

take on local authority work irregularly, or who have contact only with certain aspects of the authority (for example, the safeguarding team). This will give a more complete picture.

Consultation Questions- Chapter 7

Question 7.1: We would like to know your views on Sections 1 and 8 of the Integrated Impact Assessment. Are there any specific areas where you feel further detail is required, or any specific issues you wish to highlight which may have an impact on a specific group?

We had a few specific comments on the draft Integrated Impact Assessment:

1. On Page 4 of the Assessment we believe that the funding challenges in the sector are significantly understated. Our Homecare Deficit report 2021 (an updated version will be published later this year) suggested that the majority of public sector commissioners (85% - see page 32) in Wales did not pay fees that were adequate to cover the necessary operational costs of delivering homecare. To note financial pressure only from increasing demand and wage inflation fails to recognise that the sector is currently underfunded in a way that is not sustainable.
2. On Page 5 the Assessment says “Commissioners in Wales mainly procure services and undertake contract management arrangements. This is challenging, due to the complexity of the market, and has resulted in under or over provision of care and support services.” It is important to recognise that under and over provision of care could actually be a result of time and task commissioning (which doesn’t give the provider or person being supported flexibility to find different ways to meet needs and achieve outcomes) and a lack of trust of providers. This is not all to do with ‘the complexity of the market’.
3. Both Page 6 and Page 17 suggest that the pay and progression framework will have a positive impact on recruitment and retention, and imply this will improve pay but there is no funding accompanying the Framework at present to actually improve pay and conditions. The Framework on its own may not have the impacts described unless funding is agreed.
4. On Page 18 the increased emphasis on social enterprise co-operatives etc. may help to develop that part of the market. However, the impact assessment doesn’t seem to consider what impact that will have on other parts of the market at all (for example, on existing independent providers).

Consultation Questions- Chapter 8

Question 8.1: We would like to know your views on the effects that any of the products presented within this rebalancing consultation would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.

What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

> Other than our comment above (Q1.3) on resourcing training and ensuring capacity, we have nothing further to add.

Question 8.2: Please also explain how you believe the products presented within this rebalancing consultation could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

> We have no further comment.

Question 8.3: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

> We have concerns that there is inconsistency in the way that Direct Payments are treated across Wales. The Commissioning Framework will most likely not cover this aspect. Individuals are able to receive direct payments with which they can purchase services from homecare providers (as an alternative to employing their own Personal Assistants, which is how others use their Direct Payments).
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> Where the service is provided by an organisation some local authorities will ensure that the Direct Payment rate paid for the service is at least equivalent to the rate that they pay homecare providers for commissioned care services. In other local authorities the Direct Payment rate is only sufficient to cover the wage costs of a Personal Assistant and is not sufficient to cover the costs of a provider organisation (in terms of management, supervision, office costs and so on).
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> We are concerned that this limits the choice of individuals and means that they are not always able to use their Direct Payments to purchase the care that they want. Being in receipt of a Direct Payment shouldn't necessarily mean that an individual must take on the management and employment responsibilities associated with using PAs. We would like to see a greater

degree of consistency in policy across Wales on this point that enables people receiving care services some choice.