Surrey Care Association

Supporting Social Care Providers in Surrey

November 2020

Reinventing Social Care

A report of the deliberations of the Directors of the Surrey Care Association

Contents

Introduction

The Covid-19 pandemic is a watershed moment in history.

It is a time when our society has held Social Care up to the mirror and seen two very different images. The first, a picture of extraordinary staff eschewing personal risk to give loving care to people in their hours of most need. The second, of a system containing many examples of individually outstanding services, but which is fundamentally broken, plagued by years of planning but little action leading to a rudderless, desperately underfunded, fragmented and misunderstood service which still manages to save the NHS from collapse year after year.

The Directors of the Surrey Care Association want to ensure that this watershed moment is marked with a new approach to Social Care. We all know it is broken. We have known this for years. Now is the time to fix it.

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I

Executive Summary

The Covid-19 pandemic has coincided unkindly with a pre-existing crisis in Social Care. It has amplified the importance of our sector, but also highlighted its fragility.

The Directors of the Surrey Care Association do not wish to stand idly by and wait for our political leaders to take action. Rather, we wish to inform and influence that process by setting out what we believe a reformed Social Care sector might look like.

Who are we?

We are Proprietors and CEOs from across the sector – older people's nursing and residential care, domiciliary care, community services, supported living and residential provision for people with learning disabilities, mental health services and day activity support. We represent large and small organisations, some profit-making, others not. Between us, our organisations support around 4,000 people, we employ 2,500 and we bring 250 years of Social Care experience to the table. We are passionate and committed providers. Several of us oversee 'Outstanding' rated services. We believe we have some worthwhile insights.

We are, perhaps, the first group of providers to offer a view on the sector as a whole. Normally, this is the preserve of government departments, policy units, or academics. Providers are generally on the receiving end of policy rather than playing a role in setting it. But surely this is wrong. Providers can bring unique insights from working at the coalface, and from representing and advocating for those in their care. And whilst others come and go, we are the permanence. It is Providers, and those who entrust us with their care and support, who will live tomorrow with the policies set today.

In the past we have witnessed tinkering attempts to fix the problems of the Social Care system, but what we really need is a bold, radical and ground breaking step-change. This report is the opportunity for us to express our thoughts and ideas as to how we might do that. Some will make sense, whilst others might be a little off-the-wall. Some you will like, but others, not so much. In considering our thoughts, however, and especially those that will cost more money, we ask that you bear one thing in mind – that perhaps the truest measure of the quality of our society and our nation is how well we enable and assist those who require care and support.

We would love this document to spark further conversation, with Providers as equal partners in the debate. We hope to stimulate an open conversation in which Providers have an opportunity to shape the landscape of social care as it continues to evolve. We would like politicians and policy makers to take note, and refer to this work as a benchmark for theirs.

In this report, we set out our key findings and recommendations.

A fresh start, with a new name and a new ethos

Change the name

Names are important. They elicit emotional responses and stir deep feelings. The emotional response felt by people on hearing the words 'Social Care' is overwhelmingly negative. It has to go. We need a name which reflects the work we do to support people to live lives of real quality. We prefer the name 'Life Care,' instead.

Role of the individual

In the old model, Social Care is something that is done to people. People are assessed by others, services are chosen by others, care plans are produced by others and reviews are conducted by others. It is time to turn this on its head, and enable people to genuinely lead their care and support arrangements. With support as necessary from families, advocates and Social Workers, people should be able to own their assessments, choose their provision, design and oversee their care plan and conduct their review. Social Care must be led by the individual, not the State.

Move on from the medical model

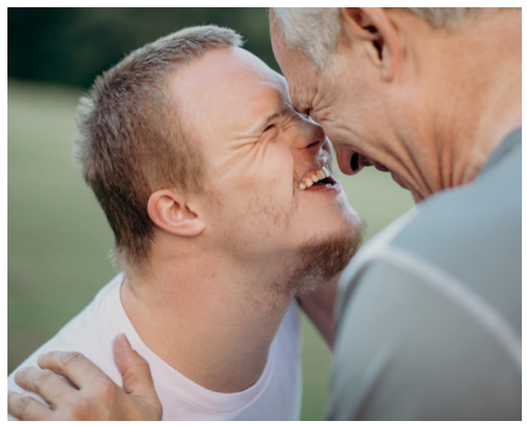
The medical model still permeates through Social Care. It is evident in assessments, care plans, reviews, registration, commissioning and inspection processes. Whilst keeping people safe and healthy will always be an important function of Social Care, models are moving on. Providers are increasingly focused on how to support people to live rich lives of real purpose, lives in which people look forward to getting out of bed in the morning. Our sector needs not just to catch up, but to take the lead.

Investment, not cost

We must start to see Social Care spend as an investment, not just a cost. It is an investment in people and their futures, and in the soul of our society.

A new status

Pre-Covid, public opinion of Social Care wasn't good. Winterbourne View and other examples of abusive practices have done us no favours. But those on the inside know that alongside the rotten, there is outstanding work being done by remarkable people day in, day out. We wish to see our sector held high in public regard for the great work it does. Social Care should sit fondly in people's hearts, just like the NHS.



A valued workforce

Care and support worker registration

We wish to see the skilled and challenging roles of care and support workers being professionalised and afforded greater status. We see individual registration as an important piece of this jigsaw. Registration would be a badge to wear with pride.

National Care Wage

Our outstanding staff must be paid at a level commensurate with the skilled and challenging nature of the job they do. We suggest a National Carer Wage set at £2/hr above the National Living Wage. As noted below, the sector will need to be appropriately funded to ensure this is affordable.

Proper terms, conditions and benefits

Our staff deserve to be employed on terms appropriate for the professional role they fulfil. Contracts should be fit for purpose – full-time where certainty is desirable, but zero-hours where staff seek flexibility. Benefits should be good, decent and modern, in line with the NHS and Local Authorities.

Promoting care and support roles

We need to change public perception of the care and support role. People working in Social Care do remarkable things, from supporting disabled people to go clubbing in Ibiza to befriending lonely older people. They change lives. But the public don't always see this, so we need an ongoing campaign to paint the true picture into public consciousness

Opening the channels

Care and support roles provide fantastic job opportunities for people, but we need to find them and draw them in. We must seek out those school leavers who are vocational care workers, those early-retirees with lives of rich experience, or those dog-walkers who are naturally empathetic. We could do this so much better.

Immigration

Many of our best care and support workers come from overseas. This is unsurprising given that they grew up in tight and caring families and communities. People come to work in the UK on the basis of a contract which works for both parties. So why did we slice through the deal? We must provide an exemption for Social Care work that provides adequate length for individuals to complete training and provide consistency for those they are supporting.

Manager training, development and qualifications

The world of Social Care is fast moving. There is a constant stream of new regulations, guidance and practices. The best services have the best Managers, so we need Managers to be at the top of their game, and to stay there. So, they must be highly trained, have a recognised and valued qualification, and engage in continued professional education. If ever there was a place to invest in the Social Care sector, this is it.

New processes, led by people who access services

High quality, ethical providers

If we can ensure that owners and senior managers of care organisations are skilled people with strong values and are authentic, ethical leaders, we will have high-quality Social Care provision. But the bar is low. There is no requirement for experience and or qualifications on entry, the registration process is not onerous, and personal values go untested. We should re-think this, raise the bar, and keep the bad apples out.

Independent assessment

There is a clear conflict of interest where the entity accountable for assessment is also accountable for placement, procurement and funding. This must change. Assessment must be independent to be objective.

We would also like to see the development of a National Assessment Framework, based on agreed best practice.

Trusted assessors

We are encouraged by recent work done to include Providers in the assessment process, and would like to see it extended. Providers are good at assessing – they know that it is in everyone's interest to get it right.

Real choice

People must be supported to exercise real choice when making decisions about the nature and Provider of their care and support.

Consistent contracting

Each Local Authority writes its own contract, often plagiarising the work of other Local Authorities when they do so. This wasteful duplication invariably produces poor-quality contracts. We should have standard, balanced national best-practice contracts which fairly define the rights and obligations of each party.

Provider owner/senior manager inspection interviews

A major failing of current inspection process is that it does not routinely include an interview with the owner(s) or senior managers. Yet it is they who shape the organisation's ethos and drive its quality. CQC is missing out on perhaps the most important indicator of service quality.

Organisational inspections

Good providers run good services. Where a Provider has proven it's values, leadership and quality over many years it is inefficient to inspect at unit or activity level. A smart and efficient organisation-level inspection would provide good assurance of quality.

Fair and transparent funding arrangements to secure a bright long-term future

National funding

Local Authorities are conflicted. They are charged with shaping a high-quality local market able to respond to the growing needs of local populations, but their funding has been constrained. It was an impossible square to circle. All they could do was tighten eligibility criteria, hammer down on fees and push wages to the floor. There are now staggering variations in areas such as eligibility, contracting, fee setting and annual uplifts. All the while, the point of doom highlighted on the Barnet graph gets ever-closer. We need a national funding solution now to ensure fair and consistent funding across the country.

A ring-fenced premium on Income Tax

Our proposals, particularly those relating to workforce, determine that the Social Care sector will require a higher level of state funding. We propose a ring-fenced premium Income tax of perhaps 1% for basic-rate tax payers and 2% for higher-rate tax payers. We are also attracted to the notion that these rates might come in or step up when people reach a certain age, perhaps 40.

Increases in Capital Gains Tax and Inheritance Tax

We see merit in making small increases in IHT and CGT to fund additional spending on Social Care.

People with means should contribute to the cost of their care and accommodation

We think it is reasonable to expect people with means to contribute to the cost of their care and accommodation. We are sympathetic to the Dilnot model with a cap on costs and a de minimis level of wealth. No need to re-invent this wheel. Time to dig it out of the long grass.

Fair and consistent fees

At present, each Local Authority sets its own standard rates for residential and nursing care. They vary wildly. We wish to see an independent Care Funding Commission set up to build a National Care Funding Formula which ensures that people have sufficient funding to choose good quality care and support and guarantees the consistency, fairness and transparency of fees across the country. This Commission should draw on stakeholders from across the sector, including Providers.

Payment of top-ups

The state must fund care at rates which enable people to choose from a range of good quality Providers, but people should also have the freedom to pay top-ups to supplement those standard rates if they wish.

Care for people with dementia should be funded by the NHS

Dementia is a medical condition, so treatment should be funded as it is with any other medical condition.

Local Housing Allowance in all models

Where people can afford to pay for their accommodation they should do so. Where they cannot, accountability for funding accommodation varies irrationally between different service models. This can be easily simplified so that accommodation should be funded from Local Housing Allowance, irrespective of the service model.

Reformed roles and structures

Social Worker role

People with the best Social Workers receive the best support. The role of the Social Worker is vitally important in many areas – carrying out assessments, supporting choice of service, ensuring that the state is fulfilling its duty of care and so forth. But we have dumbed down this role, so jobs are filled with less-qualified people operating through sanitised processes. Many people in receipt of services don't even know who their Social Worker is. We think this is a great loss, and that the trend should be reversed. Investment in social work must go hand in hand with investment in Social Care.

Role of Health and Wellbeing Board

We have wrestled with the compromised and troubled role of the Local Authority in the Social Care system. It competes with itself for resources. It assesses, commissions, manages and delivers services. It re-invents every wheel. It behaves like the monopsonistic purchaser it is. It pulls the sector from pillar to post, with each incumbent Director ringing a new vision and new direction.

We see localisation as a good thing, but wish to see an independent entity playing a role where objectivity is important. We propose building on the Health and Wellbeing Board foundation for this. This draws people from across the sector, and can oversee policy-setting, assessment, commissioning, arbitration and other processes for which objectivity is key. We would like Surrey Care Association and similar representative bodies to have representation on this Board.

We see this project as the start of a dialogue which we hope will drive reforms which benefit those who rely on our care and support. We unashamedly seek to influence the agenda and shape the thinking of those with the power to make positive change happen. We want this project to grab the attention of the people who actively shape Social Care policy – to politicians, nationally and locally, to civil servants in the DHSC, Treasury and elsewhere, to Officers working in Local Authorities and the NHS, to people working in policy organisations, to people in trade associations, and to fellow Providers.

We are pleased to present these thoughts as the start of this conversation. To be fit for purpose, Social Care must change everyone's life for the better, but to do so it needs radical reform, and it needs it now.

II

Our Mission

The Covid-19 pandemic has provided a unique opportunity to review the current condition of Social Care in the context of a consensus of goodwill and renewed public interest.

The Directors of the Surrey Care Association, as representatives of the Provider community, seek to influence the Government to radically reform Social Care in order to:

- Secure great outcomes for the people it serves.
- Recognise and value those who those who work in the sector, including fair reward and supportive development.
- Understand the true value of Social Care in all its dimensions.
- Deliver value to our society and state.

We want to reform relationships between Social Care Providers, local and national Government and the NHS to be positive, collaborative, pro-active and consistent.

We want to see Social Care recognised and respected by the public for the excellent social and wellbeing outcomes it helps people to achieve.

At its best, Social Care helps people to live rich and purposeful lives of real quality. We want this to be the norm.

III

Objectives

We embark on this work with four objectives:

1. Deepen the understanding of Social Care

As a starting point, we want all stakeholders to have a shared understanding of what Social Care is – those we support and care for, their families, those involved in shaping the sector, those involved in commissioning, procuring, providing and overseeing services, and the public at large. This is key to moving forward to achieve a collaborative and cohesive Social Care system.

2. Affirm and reinforce the value of Social Care

We see Social Care as an investment, not an expense. For too long it has been regarded as the latter. We will all one day either rely on care provision ourselves, or for the care of a loved one or relative, so Social Care has to employ models which stand the test of time and work for us all.

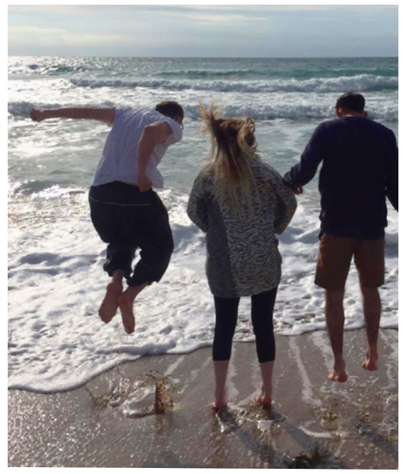
3. Identify proposals for reform

We seek to identify potential reforms in many areas. Our review will include:

- Consideration of the inputs into the Social Care system, and how they will be funded. It is critical that we find long-term funding solutions. The long-term dynamic of fee erosion and cost increases has left our sector woefully underfunded.
- New system processes which are as person-led as possible. The Social Care environment has proven its resilience, but innovation is long overdue in many areas of our sector. What we need are better processes which improve the individual's experience of Social Care, from assessment through to service delivery. We also need better processes which wrap around the individual and enable the system to operate, such as creative commissioning models which target the best achieving the best outcomes for all.
- Valuing, recognising and professionalising the Social Care workforce (including commensurate terms and conditions). There is a wider cultural issue regarding social care as a career path. We now have a real opportunity to change this perception by radically transforming the Social Care employment market. We need to ensure that people who enter the Social Care workforce have longevity – that pathways exist to facilitate long term career development.
- To fully integrate care and the community and replace the institutional aspects of care provision in a way that ensures all users feel at home and fully engaged in decisions on their care, lifestyle and future.

4. Promote the adoption of proposals for reform

When we have identified proposals for reform, we will work to maximise the chances that they will be adopted. This will require us to identify the key policy makers and engage in a marketing and public relations campaign to reach them.



IV

Ethics, values and principles

We will explore the first of our objectives, to define Social Care, in the next section. In the first instance, though, we wish to set some context for the sector and what it does.

Social Care comprises many different types of services, delivered by a wide range of organisations, from large, investment-backed nationals to small, local charities. Their objectives will vary, but there is perhaps more commonality than might be imagined. Almost all organisations, for example, need to be profitable to maintain financially viability and build for the future.

There is also commonality in the degree to which provider organisations share a desire for Social Care to deliver great outcomes for the people who access services. This is not universal, of course. We read in the newspapers about a tiny minority of bad apples operating care organisations. But the majority of provider organisations are led by ethical people with strong values who have positive aspirations for Social Care and want to do the right thing by the people for whom they care and support.

Providers wish to see Social Care built on firm principles and operating within a clear ethical framework. The best Social Care has principles in common. All good providers will recognise them. But how can we be assured that they are the right principles? The litmus test is whether they withstand the question 'If I was accessing Social Care, is this experience I would want?'. We have identified a number of desirable principles which all appear to withstand this test:

- **Social Care should respect peoples' rights**
  The Care Act (2014) defined the rights of people, but they seem to have got lost in translation. The rights of many people in receipt of Social Care services still go un-respected. This needs attention.

- **Social Care should be personalised**
  We are all individuals. We have unique circumstances and unique aspirations, and what we each want from Social Care is different. Provision must be tailored specifically to individual requirements. One size does not fit all.

- **Social Care should be person-led**
  People, or those close to them, know what they like and often what is in their best interests too. People should be enabled to shape their services to the maximum extent possible.

- **Social Care should be non-judgmental**
  Social Care is not here to judge, and support must be provided irrespective of cause.

- **Social Care should build on people's strengths**
  Much good work has been done on strength-based approaches to Social Care. These approaches re-enforce personalisation, and link to a more general virtue of seeing the best in people, recognising their talents, and seeing abilities rather than disabilities. It is a really positive concept.

- **Social care should build individual value and self-esteem**
  Whereas the NHS is about providing a fix or a remedy, Social Care is about building lives. People who access Social Care often lack self-esteem and perceive their lives to be of low value. Social Care seeks to remedy this by supporting people to a place where they are, and feel, like worthwhile members of society.

- **Social Care supports independence**
  Regardless of how superbly care and support is delivered, no-one really wants to be on the receiving end. Who would choose to have someone assist with personal care if there was an alternative? People would much rather live independently, with less reliance on others. Social Care must never lose sight of this and simply accept the status quo.

- **Access to Social Care should be universal**
  We are all individuals, and what we require of Social Care varies from person to person. Access to services, however, must be universal and non-discriminatory. At present our system is far from universal, with access dependent on where you live and how much money you have.

- **Social Care should be seen an investment not an expense**
  So often our society sees Social Care as an expense, but actually it is an investment. It invests in people to support them to achieve positive outcomes, and it is an investment in our society too, as people move from dependence to making a positive contribution. This is not always measurable in financial terms.

Moving forward, these elements must underpin all aspects of how Social Care is designed and delivered. They are the litmus test of whether we have got it right.

V

What is Social Care, and what should it be called?

What is Social Care?

In past times, we lived in a culture of communities caring for each other in times of need. But society has moved on – people have relocated, families have dispersed, communities have fragmented. Accessing external support is sometimes the only way a person can obtain the assistance they need. We have progressed to a point where Social Care is the backbone of our communities, a lifeline for families who would struggle to provide care and support alone.

As providers of Social Care, we have a good understanding of what we do. We support elderly residents to enjoy their last years with compassion and joy. We provide people with learning disabilities with a safe place to live and appropriate support to enjoy progressive, enriched and independent lives in the community. We provide vital care at home following a stay in hospital, or maintain the independence and comfort which people gain from staying in their own home. We support a million people in a million different ways, every day.

How do we do it? As with so many things in life, we follow a process. The Social Care process has inputs, conversion processes and outputs. As you will go on to read, this simple process model has been helpful in structuring our work and this document.

Firstly, the inputs. The obvious inputs are people (managers, care and support staff, specialist staff and other staff), accommodation, and the other elements which go into supporting someone – such as food and the provision of activities. These are important to consider in part because they are where the money is spent.

The Social Care conversion processes fall into two categories. Firstly, there are those processes which relate to an individual episode, such as assessment, choice of service, service delivery and review processes. Then there are those processes which wrap around the individual processes and enable the system as a whole to operate. These include policy-making, commissioning, procurement, registration and inspection.

Finally, there are the outputs, which is where we Providers prefer to hang our definition of what we do. It is outputs which lie at the heart of Social Care. In particular, we are drawn to the following:

- **Outcomes**
  Social Care is about supporting people to achieve desired positive outcomes. Building on the principles defined above, it is vital that outcomes are defined by the individual, not determined for them.

- **Wellbeing**
  A key outcome for many people is wellbeing. This encompasses notions of health, happiness and comfort, but there is a risk of over-simplification. What one person feels is their perfect state of wellbeing may be completely different from that of someone else. We all have different goals, ambitions and personalities. In reality, wellbeing is a multi-faceted concept which embraces all aspects of our lives.

  For many, the journey to wellbeing is complicated, requiring a range of issues to be addressed and overcome. Some might be health-related, in which case help and support will be provided by the NHS. All the others – social, emotional, psychological and often physical too, in fact everything which goes into making a life – are the domain of Social Care.

  Implicit here is the holistic nature of Social Care. Whereas the NHS focuses singularly on matters of health, Social Care is about the whole person.

- **Quality of life**
  Most people aspire to achieve what they perceive to be a good quality of life. But for many people this goal is sometimes unattainable without support, often for reasons beyond their control. Social Care is the system which provides this support, enabling people for whom life has become a struggle to start living a life of quality once again.

  For many people maintaining wellbeing is a pre-requisite for achieving a good quality of life.

- **Whole life**
  Social Care is enduring. It is about the whole of a person's life, throughout their life.

- **Progressive**
  Social Care is not about maintaining the status quo. It is about supporting people to make positive and progressive changes in their lives. In the best cases, the investment in the person enables them to shift from a position where they are a draw on state coffers, to one in which they replenish them.

You may have spotted that the word 'need' has not been used so far in this paper. This is deliberate. So often in the past, Social Care has been described in terms of meeting peoples' needs, but our view is that the concept of meeting needs is overly transactional, speaks to an outdated medical model, and detracts from what modern-day Social Care is really about. An older person living at home who cannot bend might need help with cutting toe nails, but Social Care is not about foot-care for its own sake. It is about supporting the person to remain independent and active, with all the benefits which flow from that.

So, in simplistic terms, Social Care can be defined as a system, but actually it is much more than that – it is about supporting people to live full, rich and independent lives of real quality. It is a philosophy.

How should a good Social Care system work?

The principles, values and ethics which should rightly underpin the individual's experience of Social Care are articulated in Section IV.

Building on these, there are a number of important concepts which are central to how a high-quality Social Care system should work:

- **Mutuality**
  There are many stakeholders in Social Care – people who access services and their families, people pursuing careers in the sector, service managers, provider organisations, social workers, commissioners, funders, policy makers and many others.

  For Social Care to work well, it must work well for all stakeholders on the basis of mutuality.

- **Collaboration and partnership**
  Beyond recognising the importance of mutuality and inter-dependence, it is best practice for parties involved in Social Care to proactively work together. None of us knows as much as all of us. Collaborative solutions based on partnership working are invariably the best.

- **Openness and transparency**
  Within the restrictions imposed by the requirements of confidentiality and GDPR, we believe that there is virtue in operating openly and with transparency. These are the foundations on which trusting relationships are built.

- **Innovation**
  Over many years Social Care has proven itself to be highly innovative. Most often, innovation has been driven by providers seeking to improve the quality of their services and support. There is no end game for Social Care – it must continue to adapt and evolve through creativity and innovation.

- **Professional**
  Excellent Social Care demands the delivery of excellent services by excellent people pursuing excellent careers. Let's change the rhetoric.

- **Value-added**
  In Section VI. we will articulate the importance of Social Care adding value to the individual – such as how moving away from a position of dependence could support the development of self-worth and self-esteem. In a similar way, Social Care adds value to our society. In part this is financial and economic – it is self-evidently better for people to be making an economic contribution than otherwise. It is more than this, though. A society's ability to provide high quality Social Care is a measure of the quality of that society. We live in the UK, the sixth largest economy in the world, in the 21st century. We really should be able to secure the value which excellent Social Care can deliver.

These concepts will be implicit in many of the recommendations we make. As Providers, we wish see them at the forefront of Social Care reform.

What's in a name?

Branding and marketing specialists tell us that the name of what they are trying to sell should convey something positive about their product. The same is true when naming companies, where the chosen moniker seeks to invoke positive emotional responses about what the company does and how it does it.

We know of no-one who likes the name 'Social Care'. The words invariably invoke a negative emotional response. The problem perhaps rests with the word 'Social'. Where else do you hear this? Social security, social club, social impact, social deprivation. Hardly positive connotations. Moreover, the word gives no sense of the exciting, progressive, outcome-based work that many Social Care services undertake.

The question of what should replace it is a difficult, constrained by the shortcomings of our language.

We like 'Life Support', but this has an established meaning. We also like 'Life Care'. This conveys something about the holistic nature of services, encompassing all aspect of peoples' lives and supporting people with often complex and inter-related issues. It also suggests something about timescale – often people will access services for the long-term. And finally, it conveys something positive about living a high quality, enriched life of real purpose.

So '**Life Care**' it is. We will use this term throughout the remainder of this document.

VI

What is the value of Life Care?

Life Care adds value to an individual who accesses services and to our society as a whole.

Value to the individual

We have covered many of the ways in which Life Care brings value to individual in Section V. where we defined Social Care. We highlighted a range of positive outcomes which contribute to physical and mental wellbeing and quality of life.

Another outcome worthy of note is self-worth. There are countless examples of Life Care services helping build a person's self-worth – a person with learning disabilities being supported to get a first job, an older person regaining mobility, an addict supported to be clean. It is a vital and often unseen role of the Life Care sector.

Value to society

- **Social value**

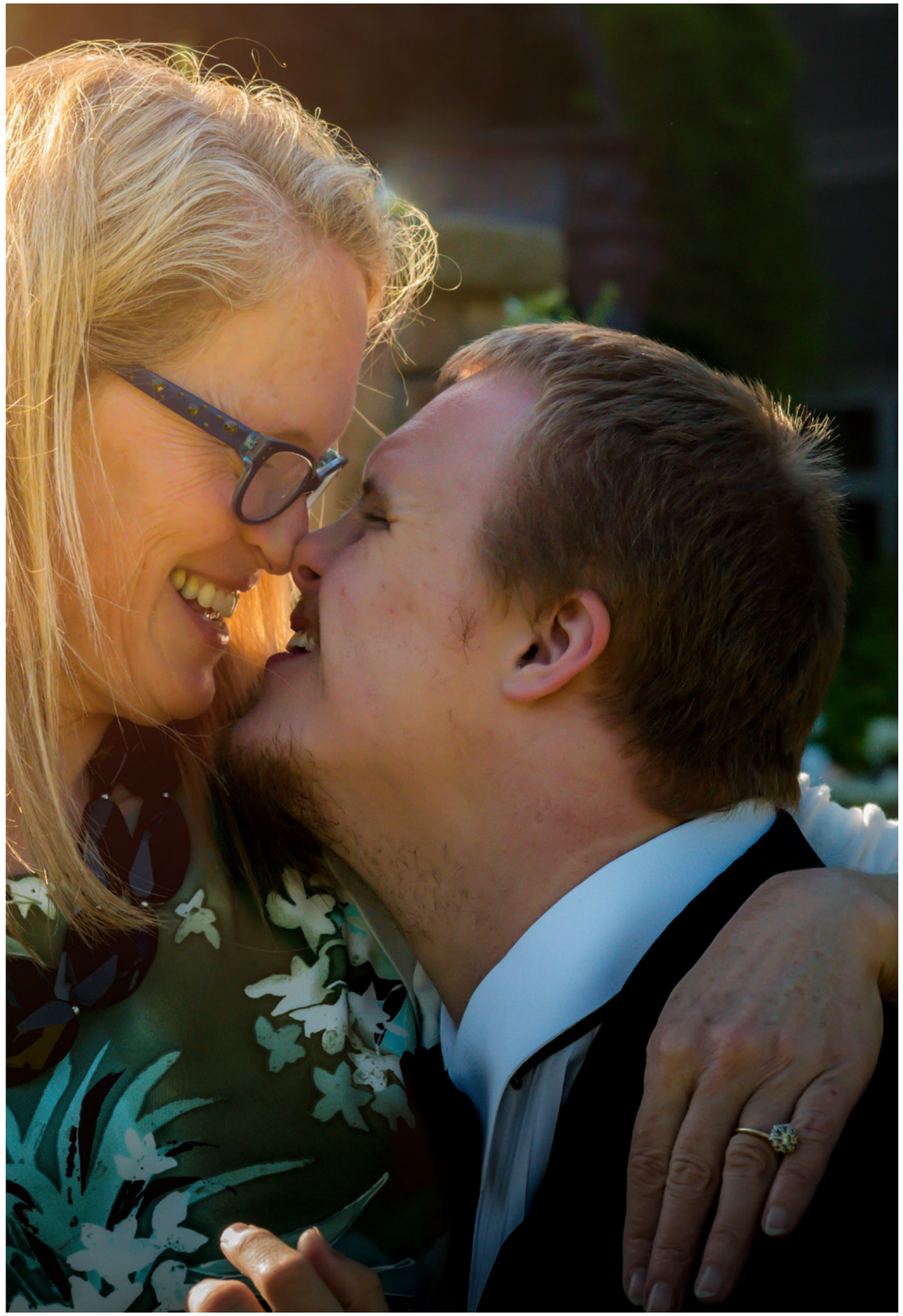
  Life Care enhances our society in several ways:

  - **A compassionate society.** Life Care seeks to help those who may not be able to help themselves. It is a measure of a mature and compassionate society.
  - **Sharing positive values.** The vast majority of people associated with the Social Care sector have strong personal values. The personal behaviours which these values underpin bring positive benefits to our sector and our wider society. It is good for society to have good people doing good things.
  - **Intergenerational understanding.** Life Care promotes the sharing of understanding, knowledge and learning between generations. What better than an older resident sharing their formative experiences with a grandchild, or groups or younger and older people spending time with each other in care settings?

- **Economic value**

  Life Care provides value for money in several ways:

  - **Reduced dependance/positive contribution.** Life Care can support some people to become more independent and make a positive financial contribution to our society. An example of this is the way Life Care has supported many people with learning disabilities into paid employment.
  - **Early intervention.** At its best, Life Care identifies issues early and gives positive support to prevent deterioration, thereby avoiding greater downstream cost.
  - **Saving costs elsewhere**. The most obvious example here is the excellent value provided by Life Care provision in comparison with the NHS. Whereas it costs £500-600 per night for just a bed in an acute hospital, a bed in a really good quality nursing home will cost around £200-300 per night, half the cost. And this includes more substantial 'quality of life' support, along with a return to an environment where any institutionalisation of the individual resulting from their hospital stay can be cured.
  - **Sector contribution.** In 2016 it was estimated by Skills for Care that there were £1.6m jobs in the adult social care sector and that the sector contributed £46.2 billion to the economy.



VII

Proposals for reform: Introduction

Almost all parties involved in Life Care, even the excellent Providers of Surrey, would agree that elements of the system are fundamentally broken. Its numerous failings include the following:

Poor provision

Our sector has much excellent provision, but there is also some poor provision. This is highlighted each year by CQC in its 'State of Care' report. In the most recent report it highlighted that almost 300 services were rated 'Inadequate'. How many people live in these services? 5,000? 10,000? You have to be a pretty bad service to get an 'Inadequate' rating, and no-one should have to live in one.

Eroding fee levels

Fee levels have not maintained pace with inflation. Starting in 2007, so our sector has now suffered 13 years of sub-inflation uplifts, or no uplift at all. Fees have eroded by over 20% in real teams.

Funding pressure driving behaviour

Local Authorities often buy as cheaply as possible. Quality is sometimes a secondary consideration.

Postcode lottery

Funding is a postcode lottery, with State-defined fee levels varying significantly form Local Authority to Local Authority. Our quick straw poll indicates that State-funded residential care can vary from less than £500pw to more than £750pw.

Staff vacancies

Fee erosion has driven a race to the bottom. Life Care has become a low-wage sector, with many people paid the minimum. Staff vacancies are increasing year on year and now number around 130,000, almost 10% of the Social Care workforce.

Staff retention

Retention rates exceed 30%, meaning that people stay in social Care jobs for only three years on average. This is not a surprise that people come and go, given than that they do a skilled and challenging job in which they are underpaid and undervalued by society. What it means for Providers is that they have to recruit a third of their workforce every year – no mean feat.

Inequitable funding rules

The threshold at which funding responsibility passes to the state is low, meaning that people can spend almost the entirety of their estate on care and support.

Ageist

Support for those needing long-term care, such as MS sufferers, is often reduced when they reach retirement age. People with learning disabilities are sometimes placed on Older Peoples' services at 65. There is ageism in Social Care.

Prejudice against dementia

People with dementia have to fund their own medical support, yet people with other medical conditions can have care and treatment funded by the State.

Inconsistent funding of accommodation

Examples include the way accommodation costs are funded in different models for people with learning disabilities and the loss of Housing Benefits for those who need to move into a Care Home.

It is clear that the way we structure, deliver and fund Life Care needs a radical overhaul.

VIII

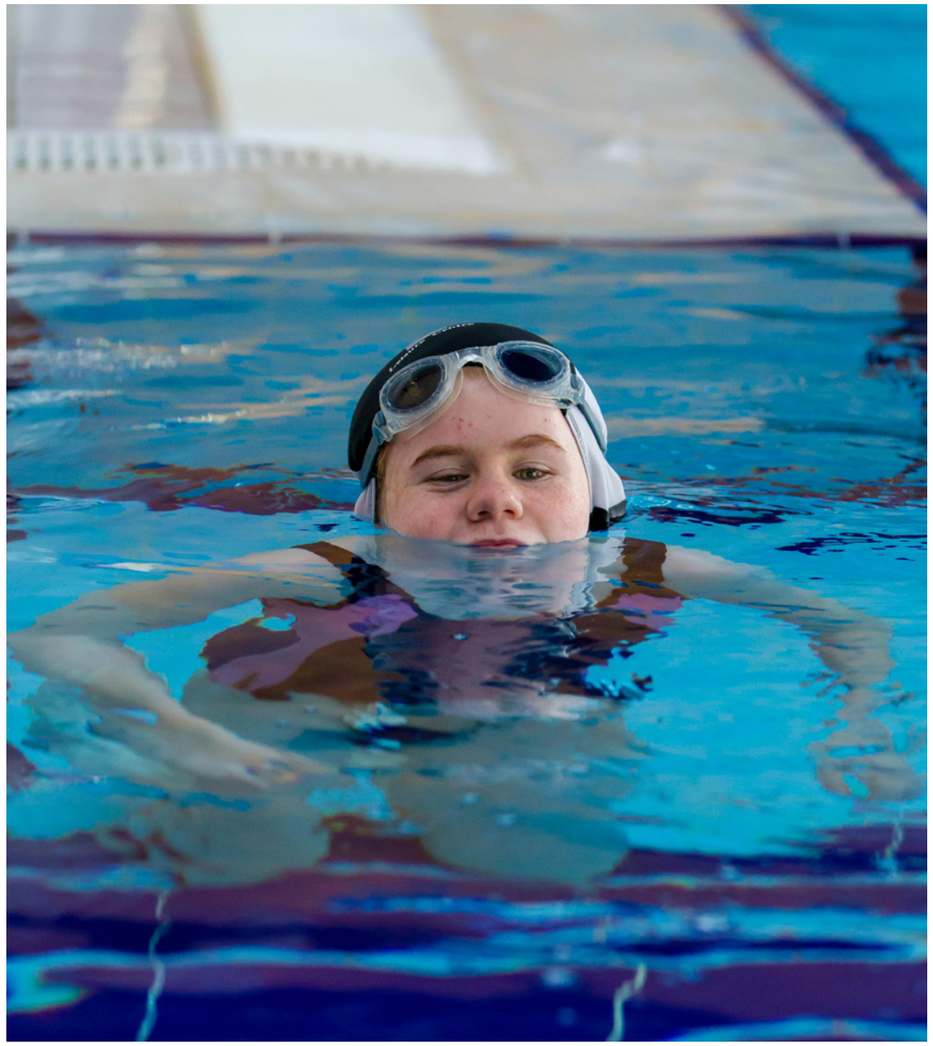
What a reformed Life Care System might look like

We have given this much thought. In the remainder of this report, we structure our deliberations and insights into three sections:

A. Life Care inputs, and who should pay for them

B. Key Life Care processes

C. Workforce requirements



A. Life Care inputs, and who should pay for them

Introduction

We have described Life Care in simple process terms, noting our preference to focus on outputs rather than inputs when describing what our sector does. It is in the outputs, the impact that we have on people's lives, that we see the value delivered by the Life Care sector.

But we can't have outputs without inputs, and consideration of those inputs is fundamental to the design of the Life Care system, so this is a good place to start.

We have segmented the inputs into the three commonly-used components of care and support, accommodation and other 'hotel' and living elements:

- **Care and support**
  This input relates to the people who organise and deliver care and support. The cost is incurred in employing and paying staff.
- **Accommodation**
  This input is the residence or dwelling in which the delivery of care and support is based (noting, of course, that much care and support is delivered away from the person's accommodation). The cost includes all elements relating to the occupation of accommodation in which the person lives and of ensuring that this remains their 'home' and not an institution.
- **Other 'hotel' and support elements**
  These are inputs which are not included in the categories above. They include food and consumables, clothes, interaction with family and friends, transport, activity costs, recreation costs, holiday and so on.

In respect of each input category we will consider who should pay for it, and from where the funds might be sourced. The categories have different characteristics, so we should perhaps expect that they should be funded in different ways.

The Life Care sector is not homogenous, so one solution does not fit all

Before moving on to consider who should fund the Life Care input categories, and from where the funds should be sourced, there is one further factor that should be highlighted – the lack of homogeneity in the Life Care sector.

There is significant differentiation within our sector between the different cohorts of people who access services. The salient cohorts are older people who access services towards the end of their lives and people with learning disabilities and/or autism who access services throughout their lives. There are other cohorts too, such as people with physical disabilities or mental health conditions. There is also significant variation within cohorts, such as the distinction between older people who have dementia and those who don't.

These distinctions are important to understand because they may impact the way the system should be designed to best support each.

In our work we will consider the most salient cohorts – people with learning disabilities and older people. We will start by considering people with learning disabilities because Life Care narratives often focus on older people to the detriment of other groups.

Care and support costs – Who should pay?

Principles

As Providers and citizens, we believe that four key principles will lead us to the answer of the question of who should pay for care and support costs:

- **Personal responsibility.** Where possible, people should take responsibility for their own wellbeing. Indeed, we believe that most people would choose to take this responsibility. Much better that we plan for our own Life Care individually than leave it to the State. We do it with our pension, so why not our care too?
- **Taking responsibility for others.** We believe that people are increasingly happy to take responsibility for paying for their own Life Care and for that of their loved ones.
- **An effective safety net.** The State must provide an effective safety net by funding care and support for people who do not have the means to fund it for themselves. This will include some services for older people and most services for younger adults.
- **Money should follow the person.** We are attracted to the notion that the money should follow the person. Funding will typically originate from three sources: the NHS, Local Authorities and the person's private funds (including pensions). With the exception of funding for health and medical care, which will be funded by the NHS, all other funds should be allocated to the individual to facilitate their choice of care and support service.

Support for people with learning disabilities and autism: Who should pay?

Care and support for people with learning disabilities has unique and specific characteristics:

- People will often access services for the whole of their lives.
- Some people need a high level of support. For example, people with severe learning disabilities need support with many aspects of their lives.
- People often have no personal wealth or assets.

Since care and support is generally unaffordable for the individual it is reasonable to expect the state to fund care and support for most people with learning disabilities. Health and care funding should be paid by the NHS and Local Authority working together, with one budget. The only exception should be where a person has the wealth to contribute to the cost of their care and support, for example where a person has inherited wealth.

Fees should be set using a National Care Funding Formula designed and overseen by a new, independent Care Funding Commission. If Life Care is to be sustainable it is vital that care fees are set at a level which reflects the true cost of care and includes a reasonable profit element. But at present this is an area where Local Authorities are happy to exercise their monopsonistic power, resulting in massive variations across the country. Some of the current rates (for both learning disability and older people's services) are lamentable.

Care for Older people: Who should pay?

The key question here is whether the state should pay for end-of-life care or whether people with sufficient wealth should cover all or part of the cost of their care themselves? In debating this question at the Surrey Care Association there has been some polarisation of opinion. Some Providers feel that, as with the NHS, Life Care for those in need should be free at the point of delivery and that nobody should feel unable to access social care. Others consider it reasonable that people with sufficient wealth should contribute to their care costs.

We see merit in both perspectives, but on balance lean toward the view that people with wealth can and should contribute to the costs of their care. People should have this expectation, just as they do with retirement. As discussed below, we are attracted by the notion that people take personal responsibility for this throughout their lives.

We do not, however, believe that people should be required to fund the whole of their care costs. This is because the totality of care cost will vary from person to person, and it does not seem equitable that one person might spend their entire wealth on their care whilst another might pass away having spent little on care, and therefore able to leave their wealth to their descendants.

We see significant merit in the proposals of the 2011 Dilnot Commission as set out in "Caring for our Future: Progress Report on Funding Reform" (HM Government, 2012). This offers financial protections through capped costs and an extended means test, as the right basis for a future funding model.

The question, then, is what levels at which the caps should be set? Several factors need to be taken into account, and a more detailed study than this will be needed to define what is fair and appropriate. A reasonable working premise, however, might be that the care costs attributable to an individual might be capped at, say, £200,000, whilst the de minimis level of personal wealth might be set at £100,000, below which the state will fund care costs.

Note that where a person does not have the means to fund their end-of-life care the state must provide funding to enable the purchase of good quality care. The levels of state funding must not be subject to a postcode lottery or the vagaries of Local Authority decision-making. As noted above, we wish to see a new, independent Care Funding Commission set up to oversee fee-setting using a National Care Funding Formula. This will ensure fair, consistent and transparent funding of state-funded care across the country.

We would make one further important point in respect of the funding of care at the end of people's lives. We view dementia as a medical condition, and we are sympathetic to the argument that care for people with dementia should be funded by the NHS in line with other medical conditions.

How should the State source funds for its investment in care and support?

In our proposed model the State will be required to fund care and support for several cohorts – people with learning disabilities and autism, older people below wealth thresholds or who have reached their cap and other cohorts too.

This funding must be provided at a level which facilitates the purchase of high-quality care and support, as determined by the proposed independent Care Funding Commission.

Moving forward into the future, we anticipate that the State's spend on care and support will need to increase significantly, both in absolute terms and as a proportion of GDP. The Dilnot Commission highlighted the Office for National Statistics' prediction that the number of adults living beyond the age of 85 will have doubled by 2030. The population of people with learning disabilities requiring care and support is also increasing year on year. At present the State does not have the means to pay for the level of provision which will be required.

We also highlight the famous Barnet Graph of Doom, which indicates that without reform, Social Care will absorb the entirety of the Local Authority's budget in very few years from now.

In 2020, we would argue that the situation has become acute. Any suggestion regarding state funding needs to consider the future generational trend that we are in a rapidly developing asset-poor society, with little capacity for long term investment or saving.

The State can only source the increased funds required to fund care and support costs at National level via the taxation system. In doing so, we feel that it is important that whatever mechanisms are used promote equality, and that wealthy individuals should contribute proportionately more according to earnings and assets. Direct taxation is arguably be the only way to fund Life Care which appropriately deals with wealth inequality, rather than using assets to determine affordability.

We are attracted to the following ideas, some of which have been mooted recently:

- A ring-fenced premium on Income Tax. This could be graded, for example 1% for basic-rate taxpayers and 2% for higher-rate tax payers.
- Stepped income tax contributions, with people over forty paying more than those below 40 simply because the additional tax is likely to be more affordable.
- An increase in Inheritance Tax rates.
- An increase in Capital Gains Tax rates.

Tax rises are never popular, but at the current time, when people have seen the true value of Life Care, people might find them palatable.

How should individuals source funds for care and support?

In the proposed model individuals will fund the costs of their end-of-life care, subject to caps and limits.

Currently, peoples' ability to pay at the point of need varies according to their wealth. Few people make specific provision for care costs so people without wealth invariably rely on the State to pick up the tab.

Where people do have the wealth to fund care costs, their wealth is often tied up in the illiquid form of property and other assets, and difficult to access.

We are attracted to the development or adaptation of personal funding schemes to create ring-fenced funds for future care costs. Through these schemes people would build a fund to pay for care and support (and other costs too). Their fund would form part of their personal estate, and be passed on with the rest of their estate should it not be spent before a person dies.

These would be compulsory schemes, working in the same way as auto-enrollment pension schemes. We would like to see these schemes supported by the taxation regime, with contributions being defined as allowance expenses and investment income on the fund being tax free.

We would see these schemes being provided by both the Government (in a similar vein to the NEST scheme) and regulated investment companies.

We expect the scheme to be administered by employers, but we do not necessarily consider that it would be wise to expect them to contribute. Pension auto-enrollment has recently imposed a significant additional burden on employers so it would be unfair to impose further cost pressures.

Note that when this fund is applied to fund care costs it will start to build towards the cap ceiling at a standard rate.

Accommodation costs – Who should pay?

Principles

In general, people have to fund their accommodation costs when not in receipt of care and support, so it seems reasonable to expect that people should continue to fund accommodation costs when they are in receipt of care and support too.

Accommodation for people with learning disabilities and autism: Who should pay?

There are a range of models for the provision of care and support for adults with learning disabilities and/or autism, but predominantly services fall into the categories of residential care and supported living.

Accommodation funding varies according to the model of care and support. In the residential care model, the accommodation cost is included as part of the overall fee and funded by the purchaser, most often the Local Authority, whilst in the Supported Living model people fund their own accommodation costs, most often funded through Local Housing Allowance (LHA).

This makes no sense. We believe that there should be consistent system in which accommodation costs for all people should be funded through the same mechanism, irrespective of the model. It should all be funded through LHA.

Accommodation for Older people: Who should pay?

Home-based care is perhaps the best example of the separation of care and accommodation costs. Here, it is clear that the individual funds their accommodation.

In nursing and residential care, however, the picture is different. Typically, people buy (or have bought for them) a package of care and hotel costs, including accommodation. These cost components are often not separately identified.

We suggest that there is merit in separating out the accommodation element of cost from nursing and residential care packages, and for this to be funded by the individual who has, in effect, downsized their home. This downsizing also has the community benefit of making more family homes available rather than having to build so many.

Sources of State funding for accommodation

The State will be responsible for funding accommodation where the person does not have means to fund it for themselves. Given prevailing systems and structures it would make sense for this to be delivered through Local Housing Allowance in all cases.

We note three further points:

1. There should be an enhanced rate of LHA to fund accommodation for people with specialist accommodation needs, such as people with severe learning disabilities, physical disabilities or dementia.
2. LHA rates should be index-linked to reflect local rates for renting accommodation.
3. The number and proportion of older people and people with learning disabilities varies significantly by Local Authority, so there will need to be a central funding adjustment to ensure that those areas with high levels are not financially disadvantaged.

Sources of individual funding for accommodation

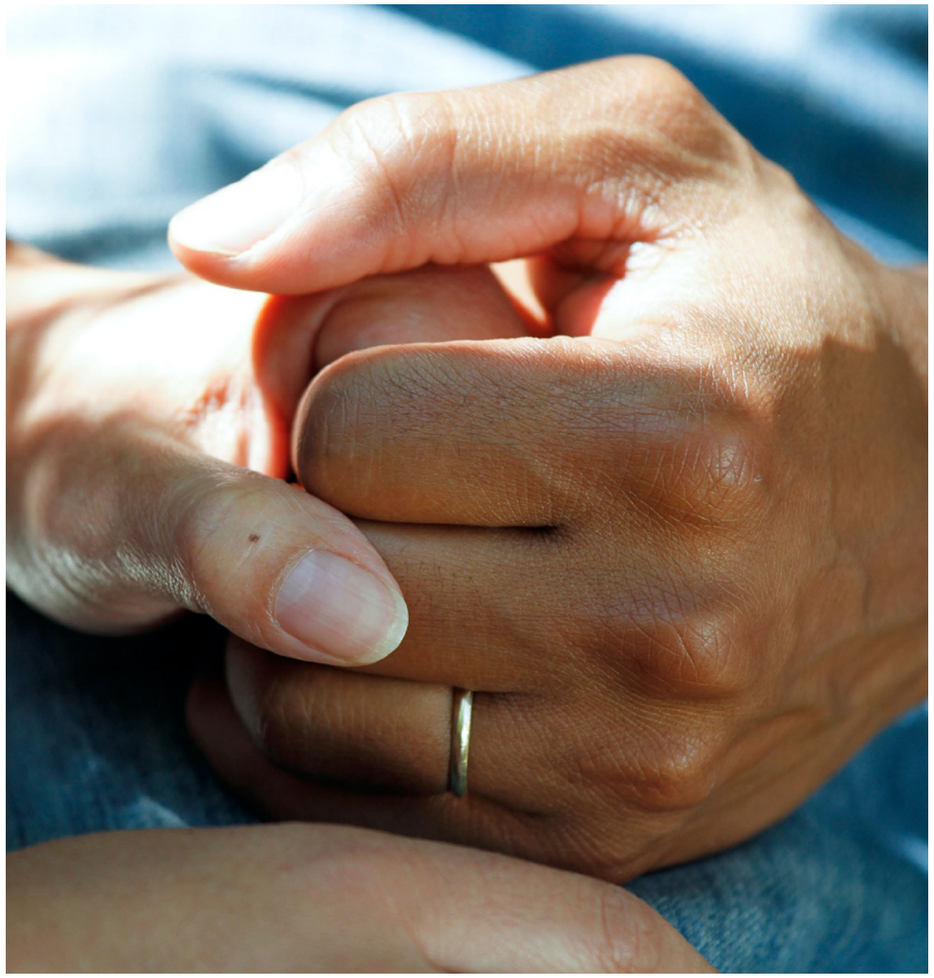
As proposed in respect of care and support costs, we are attracted to personal funding schemes as a vehicle to fund accommodation costs too. Building this fund will give flexibility to those who don't want to sell their houses, but if they have run out of money and still choose to sell their house this could remain as an option.

Other Hotel and Support costs – Who should pay?

Other Hotel and Support costs can include a whole raft of costs. Examples of costs which might be in this category include food, activity support, personal services and transport.

In those models, such as Supported Living, where people tend to live as tenants, people fund these costs themselves, often through benefits. In the residential care model, however, many of these costs will be included in the overall package price. Precisely what is included will vary from Provider from Provider.

As with accommodation, our view is a simple one. These costs should be funded by the individual, just as they would be if the person was living anywhere else. If they are not affordable, then the person should fund this expense through their benefits.



B. Key Life Care Processes

In the previous section we identified the key inputs into the Life Care system, considered who should fund them and suggested how that funding might be sourced.

Now we move on to considering the processes which, taken together, make up the Life Care system. The processes are what Life Care does. They are how the Life Care system takes inputs and converts them into outputs.

Life Care processes can be divided into two broad categories:

- **Individual episode processes**
  These processes relate to the person's experience of accessing the Life Care system. They start at the point where the person requires a service, and end when he/she no longer needs that service. Some people will access Life Care services for the whole of their lives, whilst others will just access a Life Care service for a limited period of time when they have a specific requirement.
- **Market management processes**
  These processes are those which wrap around the individual episode processes, creating the environment in which those processes can operate efficiently and effectively. Policy-setting, commissioning, regulation and inspection fall into this category.

We will specify the processes within each of these broad categories, suggest the characteristics the process should have in the new and improved Life Care system, and define who should be accountable. Our observations on the failings of current processes are set out in Appendix I.

The design of Life Care processes will need standardisation within a national framework, but with flexibility for adaptation at local level. There are different needs and emphases within individual communities and counties. In the past there has sometimes been a failure to recognise the need for processes to be locally adaptable.

INDIVIDUAL EPISODE PROCESSES

The Assessment Process

Assessment is the process of determining a person's ability in different areas of their life, and therefore their requirement for care and support.

Under the Care Act 2014, Local Authorities are required to carry out an assessment of anyone who appears to need care and support, regardless of whether they are likely to be eligible for state-funded care.

What characteristics should the assessment process have in a redesigned Life Care system?

The assessment process in the new Life Care system should have these positive characteristics:

- **Person-led.** The assessment process should have its subject at the heart, and be driven by the outcomes he/she wants to achieve. This should include consideration of the type of service which the person wishes to access. The person should have access to family support and independent advocacy where necessary.
- **Emphasis on wants and aspirations.** We should move on from the Medical Model. Life Care is not about keeping people alive – it is about supporting people to live a rich life of real quality.
- **Independence and objectivity.** Local Authorities must not be accountable for assessments due the inherent conflict of interests this creates. We can't have a compromised value chain where the same entity assesses, chooses, funds and sometimes provides services.
- **Consistency of process.** We would wish to see a new, best practice National Assessment Framework applied across the country. It will need to be highly flexible to apply to all circumstances.
- **Consistency of eligibility.** We would also wish to ensure that if a person is assessed to need a service, they should receive it irrespective of where they live.
- **Avoidance of duplication.** People should not be subject to repeated assessments by Local Authorities and Providers. A single assessment of the right scope and quality should be enough.
- **Assessor quality.** Assessment is such an important process – get it wrong and everything which follows will also be wrong.
- **Trusted assessors.** The Provider community, with its extensive experience and great skill, is very well placed to participate effectively in the assessment process. This is not, though, a proposal for assessment to be done on the cheap. Trusted assessors should be paid for their role. Safeguards against potential conflicts will also need to be built in.

Who should be accountable for the assessment process?

We would like to see accountability for assessments sitting with an independent body. We do not, however, want to see the creation of a national assessment behemoth. Rather, we propose that the assessment process is operated at local level, where accountability could sit with a re-imagined Health and Wellbeing Board.

Our vision for the Health and Wellbeing Board is that it could play an active independent leadership role at the heart of Life Care and Health system. As currently constituted, Health and Wellbeing Boards are chaired by Local Authority elected members and include representatives of CCGs and Healthwatch, as well as Local Authority representatives. We would wish to see the following reforms:

- Reconstitute with wider representation, including Providers
- Make the Health and Wellbeing Board accountable to the Department of Health and Social Care, rather than the Local Authority
- Professionalise the Chair role and create other funded roles as required
- Broaden the accountabilities and responsibilities

The Assessment process should be carried out by high-quality people – senior care managers and other experts drawn from across the sector, with specialist skills as necessary. We should not expect a Care Manager who works primarily with older people to assess an autistic person.

One final point here. It must be clear to all parties involved the Assessment process that the assessment is being produced on behalf of the person, and that once produced, it is owned by the person. It is their assessment.

The Choosing Process

In the old Social Care system, the closest approximation to the Choosing process is the Placement process. However, we are keen to leave the concept of placement behind, conveying as it does the parent-child sentiment of something being done for or to someone by someone else – in this case the State.

In re-naming this process as the 'Choosing' process, we recognise the need to shift the balance so that control rests firmly in the hands of the person who needs to access Life Care. Personal choice is essential.

What characteristics should the Choosing process have in a redesigned Life Care system?

The Choosing process in a new Life Care system should have these positive characteristics:

- **Choice.** People must choose the provider of their care and support, irrespective of whether the state is paying. This choice is potentially restricted by funding, but we wish to see state funding set at a level which enables people to have a good choice of high-quality care and support options.
- **Top-ups.** We would want people to have the freedom to pay top-ups personally if they want to buy higher-cost care and support or accommodation which is priced higher than the level which the State will fund.

- **Person-led.** As with the assessment process, the choosing process must have the person at its heart. The person's involvement should be maximised, with family and advocacy support if necessary.
- **Care planning.** As with assessment, we would want to see the design and implementation of a new national Care Planning Framework, to be applied consistently across the country. Care Plans will become broader, focusing on aspirations and quality of life as well as health and wellbeing. The Care Plan will be produced by the assessor, with maximum involvement from the subject. This will ensure that there is only one care plan and that all parties are working to it.
- **Guidance.** There is a need for national best-practice guidance so that people are enabled to exercise their choice expediently and wisely.
- **Market insight.** We would like to see a National Register of Providers with easy search facilities which enable people to analyse and understand the market, and target their choosing process. We note that the Care Quality Commission website does include a search facility, but it is not designed from the perspective of a person choosing a service, and it only includes registered provision. It is, of course, helpful for a person making a choice to read inspection reports once they have become aware of a prospective service.
- **Provider information.** We would like to see guidance given to Providers about the minimum information they should have available to people choosing care and support. This might sit on the national register.

Who should be accountable for the Choosing process?

There are two elements to consider. Firstly, there is the question of who should be accountable for making the choice. This must rest with the individual who requires the care and support. Where appropriate and necessary, the person should can receive support from family, Social Workers and advocates.

Secondly, there is the question of who should be accountable for administrating the process. We see this firmly within the remit of Life Care professionals working within for the Local Authorities. As Providers, we have great respect and admiration for the work done some of the excellent Social Workers we have worked with over the years. It has long been the case that the people who get the best from the Social Care system are those with the best Social Workers. However, we are also saddened by the way this role has been dumbed-down in recent years, with much of this important work now done by less-qualified Social Care Practitioners through mechanistic and impersonal processes.

The Service Delivery Process

Service delivery is the process of providing care and support services to people who require those services.

There are currently a wide range of organisations providing care and support services, as defined by these variables:

- **Profit and not-for-profit**
  We use the term 'not-for-profit' because it is in common use to describe charities, housing associations, friendly societies and other entities which are not privately-owned, but it is misleading. All organisations need to make a financial surplus to be sustainable and facilitate reinvestment. The differentiation is really that these organisations are not owned by individuals, and that profits are being invested in entirety, rather than potentially distributed.
- **State and non-state**
  State provision is operated by Local Authorities and the NHS. The volume of state provision has declined over many years as non-state provision has grown. In Surrey, we are seeing a reversal of this trend, with the Local Authority taking back services which were previously contracted out and pursuing plans to develop accommodation. We see this a failure of market shaping.
- **Form of private ownership**
  There are several variants of private ownership, from individual/family-owned organisations to companies owned by investors.
- **Size**
  Providers range from one-service organisations to those with hundreds of care homes. Economists comment that the market for care and support is 'immature,' with a long tail of small providers and relatively little consolidation compared to more mature markets.
- **Local/national**
  Some organisations operate locally, whilst others have a regional or national footprint.

What characteristics should the service delivery process have in a redesigned Life Care system?

The service delivery process in a new Life Care system should have these positive characteristics:

- **High quality, ethical providers.** This is the starting point. If we can ensure that all provision is delivered by high quality, ethical providers then people will have good options from which to choose and an excellent chance of receiving great care and support. A number of changes would support this aim:
  - **Expectations and messaging.** The DHSC, CQC and other policy-shaping bodies should set clear expectations about the qualities required of providers and deliver positive messaging to reinforce.
  - **Training.** At present there are no training requirements for providers. We see training as essential to give people the skills and knowledge to fulfil their role effectively. We also see this as a healthy barrier to entry.
  - **Qualifications.** We suggest that providers should have to achieve a mandatory qualification to own and lead a care and support organisation. Continued Professional Education would be in place to keep knowledge up-to-date.
  - **Transparency.** Information about the people leading care and support should be freely available to people accessing care and support services. This should include compliance with training requirements.

- **Maximum 'skin in the game'.** Service delivery works best when the proprietor and service delivery managers have a deep, strong and enduring relationship with their organisation, either through ownership or a strong commitment to its Mission and alignment with its values. Remote external investors do not fall into this category. Where an organisation has remote owners, the requirement for service manager commitment is heightened.
- **Effective managers.** The best services have the best managers. We would like to see a greater focus on Manager training and qualifications.
- **Local knowledge and place in community.** The best services typically reach out to their local community and find a valued place within it.
- **Participation in the sector.** Good organisations are outward-looking. They participate actively in their provider community by joining fine representative organisations like the Surrey Care Association. They do so to stay abreast of sector issues, absorb best practice, further the development of the sector and, importantly, to give support to others.
- **Employee/user ownership.** One structural problem is that as owner-operated organisations grow and providers look to retire, their exit is often via sale to an investment company. We would like to see the active promotion and incentivisation of more positive alternate exit strategies, such as employee ownership, or ownership by people who access the service.
- **Funding and economics.** Funding needs to be sufficient to drive person-centred models, which can be more expensive.

Who should be accountable for service delivery?

Given what we know about the characteristics of good services, we see virtue in care and support being delivered by a rich and diverse mixed market of providers.

We believe that some forms of organisation have characteristics which are consistent with the delivery of high-quality care and support – those with skin-in-the-game, local knowledge, a valued place in the community, high participation levels and so on. We would like to see positive encouragement given to those forms of organisation.

We would like to see the market operate efficiently so that poor providers exit the market.

We do not see a significant role for State provision of Life Care.

The Review Process

The purpose of the review process is to provide an opportunity to:

- Reflect on what is working and not working about the Care and Support Plan and the way it is being delivered
- Consider what may need to change about the Care and Support Plan
- Make sure the plan remains relevant to the persons needs and aspirations
- Identify the need for any reassessment
- Mitigate the risk of people entering a crisis or safeguarding situation

Without a process for regular reviews, plans could quickly fall out of date, so people might not receive the Care and Support they require.

What characteristics should the review process have in a redesigned Life Care system?

The review process in a new Life Care system should have these positive characteristics:

- **Approach.** We would like to see a move away from the mechanistic, tick-box approach which is often taken, and see greater innovation in the way reviews are held.
- **Person-led.** The review must be owned by the person who is the subject of the review. We see this as process where it is the person themself who takes stock of how things are progressing, in the nature of self-reflection or self-assessment.
- **Form and content.** The person should define the form and content, with help and support as appropriate.
- **Positivity.** The review should be celebration of what has gone well as well as a forum to discuss what needs to change.
- **Aspirational.** As well as a celebration, the review process should focus on a person's progress towards achieving their aspirations, and determining what needs to change to ensure that big life goals are achieved.

Who should be accountable for the Review process?

Accountability for the review should rest with the individual who is to be the subject of the review. Where appropriate and necessary, the person should receive support from family, Life Care professionals (Social Workers) and advocates.

We do understand that there will be some information which the Local Authority needs to capture to ensure that the state is fulfilling its duty of care and achieving good value for money for the public purse. It might be that these objectives will be met through the person-led review process, but if not, then alternative mechanisms will need to be sought.

MARKET MANAGEMENT PROCESSES

The Policy-Setting Process

If we think of policy as a set of actions and decisions which are taken solve a problem or address an issue, then policy-setting is the process through which those actions and decisions are determined. There are various models to describe this process. Typically, they start with a requirement to put the public problem on the agenda and then trying to solve it. This is then followed by analysing the issue or problem and formulating a policy to address it.

In respect of Life Care, we can distinguish between national and local policy-setting. National policy-setting, undertaken by the Government, sets the strategic framework for the sector and determines how it should work. Local policy-setting, undertaken primarily by Local Authorities, shapes local policy in response to local issues and conditions, often in context of national policies.

Policy-setting is influenced in several ways. We hope that the journey followed by this report will be an example of how this works in practice.

What characteristics should the Policy-setting process have in a redesigned Life Care System?

- **A place on the agenda.** Keep Life Care high on the agenda, and don't shy away from the difficult task of sorting it out.
- **Clear accountabilities.** It should be clear who is accountable for policy setting at national and local level.
- **Measuring and monitoring.** When you know who is accountable, you can then measure how well that accountability is being exercised.
- **Inspection.** As part of the oversight regime we would like to see local policy-setting processes subject to external inspection and review. We really do need to make sure this is being done well. It is fundamental to everything else.
- **Standardised processes.** It seems obvious that there should be standardised best-practice processes for setting policy. These may exist, but if so they are opaque to us, and we see no evidence of them being used.
- **Education.** Policy-setters need to be really good at it! We need to ensure that they are appropriately trained to ensure that they can fulfil their policy accountabilities as well as possible.

Who should be accountable for the Policy-setting process?

At national level, it has to be the Government which is accountable from policy-setting. Policy should be shaped at high level by the Prime Minister, the Minister for Health and Social Care and the rest of the Cabinet. Important roles will also be played by other politicians, for example the Social Care Minister and the Chair and members of the Health and Social Care Select Committee. Senior Civil Servants in the Department of Health and Social Care are heavily involved in policy-setting too.

We are particularly attracted by the notion of having a National Policy Director for each area of Social Care who has policy-setting responsibilities.

At local level, we see a reconstituted Health and Wellbeing Board taking accountability for policy-setting. We can see that, with clear accountabilities and proper resources, this could result in high quality, long-term policy-setting. The Local Authority would become an implementation and delivery mechanism.

We would also like to see Policy Directors for each sub-sector of the Life Care system at local level too. This would enable there to be co-ordination of policy between national and local levels.

The Commissioning Process

Commissioning is the long-term process by which health and care services are planned, purchased and monitored. More specifically, it includes the following process elements:

- **Strategic planning**
  This includes assessing the needs of the population, reviewing service provision and determining priorities for market shaping and development.
- **Shaping services**
  A key element of commissioning is to design and shape services and manage capacity.
- **Monitoring and evaluation**
  Commissioning should include keeping an oversight of the performance of providers and the market as a whole.

There have been a number of authoritative studies of Commissioning in recent years, an example being the LGA study 'Commissioning for Better Outcomes'. We agree with many of its views and findings. Our review is far less thorough or considered, but we will share our experience-based observations.

What characteristics should the Commissioning process have in a redesigned Life Care System

The Commissioning process in a new Life Care system should have these positive characteristics:

- **Performance.** We wish to see all Commissioning functions performing well. This means getting the basics right – understanding the needs of the population and the future demographics, then shaping the market to deliver services which meet those needs. It is such a simple notion, but somehow it seems to get lost in translation.
- **Signposting.** An important aspect of performance is the quality or the signposting given to the Providers. Providers should be in no doubt about type of services which are required in a locality so that they can tailor their development plans accordingly.
- **Creativity.** We wish to see innovative and creative commissioning which promotes the development of high-quality services which change peoples' lives.
- **Connectivity.** Commissioning functions need to be well connected with all stakeholders in the Life Care systems. It is through relationships and links that Commissioners can obtain data, information and insight, and influence and shape the market. An example here is the requirement for Commissioners to link with people approaching transition and their families so that they can shape the development of services to meet their needs and wants when they leave school.
- **People-led.** People who need to access to services should be given a heightened role in Commissioning. This would, in turn, place the requirement for higher-quality service back at the heart of the function.

- **Long-term lifecycle planning.** We wish to see Commissioning take a long-term view. For some people, Lifecycle planning might indicate that up-front investment in the development of skills and capabilities might increase their independence and reduce long term support needs.
- **Separation from Procurement.** Commissioning is a strategic function, whereas Procurement is largely operational. They don't need to be conjoined.
- **Inspection.** We would like to see Commissioning functions being inspected by CQC.

Who should be accountable for the Commissioning process?

We would like to see Commissioning acting objectively in its role. We want to see it free from imposed funding constraints, able to analyse, design and shape the market based on quality rather than cost. We want to see its work driven by the people who will use services. We want to see it as a forward-thinking and creative process.

Just as we argued that the Assessment process could sit independently, overseen by a newly re-constituted Health and Wellbeing Board, we could see Commissioning being overseen in this way too.

The Registration Process

You would think that the best place to go for a definition of the registration process and why it is necessary within the Life Care system would the Care Quality Commission website, but you would be wrong. The opening paragraph of the 'Why register?' page states:

> "Any person (individual, partnership or organisation) who provides regulated activity in England must be registered with us otherwise they commit an offence."

A slightly unfortunate emphasis!

Much better to think about why we need to have registration in the Life Care system. The answer is that registration manages away some of the risk of poor-quality provision at the outset. To mix a metaphor, it weeds out the bad eggs.

Bone fide providers who set out to deliver high-quality services see this a very good thing.

What characteristics should the Registration process have in a redesigned Life Care System?

A great registration process would have these characteristics:

- **A high bar.** A high bar is vital that provider registration is made to be as failsafe as it can possibly be, so the bar must be set really high. We would wish to see three new elements:
  1. Training and qualification. In the past (although not currently), Registered Managers had to be trained and qualified. Registration was contingent of them having, or studying for, a Registered Managers Award which linked to NVQ Level 4. We believe this had merit.

     However there has never been any requirement for providers to have any training or qualifications. We see this as a major failing. Our society requires us to train and pass a test to drive a London taxi, teach children or take blood, but there is no requirement for training or qualifications to operate a care and support service. This is nonsensical given the great skill required to operate a successful care and support organisation, and the huge accountability which the position attracts.
  2. Experience. Providers do not presently need experience to be registered. We also see this as a failing. We believe there should be de minimis experience requirements of, say, two years working in the sector.

     The requirement for experience will bring multiple benefits. It will teach potential owners and investors whether they have a true affinity for the sector, enable people to learn valuable skills at the coalface and facilitate judgement by others working in the sector (see below). It may even dissuade people who are just in it for the money.
  3. Professional references. If providers seeking registration have worked in the sector, then they will have been observed doing so. This facilitates referencing by people with whom they have worked who will have first-hand knowledge of their qualities and values.
- **Professional registration.** Many professionals will grumble about Continued Professional Development. But it serves a purpose, keeping people current. In the Life Care sector things move at a pace, so there is a requirement for something similar. Providers and managers who are not prepared to put the time and effort into keeping up to speed should forfeit the right operate.
- **Ongoing referencing.** Furthermore, on a periodic basis providers and managers should have references re-checked. The longer people work in the sector the more they develop a reputation, good or bad, providing an invaluable insight which currently goes unchecked.
- **Re-focused Registration.** The most important aspect of registration is not accommodation, or systems, or processes, but people. We need registered providers and managers with the utmost personal integrity and exemplary values.
- **Outcome-based Registration.** Registration focuses on inputs, but we need to be registering people and services who can support people to achieve brilliant outcomes. We should be registering those who have a passion for supporting people to live rich and purposeful lives, and to do with have kindness and compassion.
- **Consider the business model.** Logic dictates that a care organisation is more likely to support people to achieve brilliant outcomes if it is led by a caring, passionate and talented owner-operator, than by a provider funded by investors facelessly investing in US real estate investment trusts. This is not to say that the latter, and similar investment vehicles, should be excluded from the Life Care sector, but it does suggest that bar to registration should be higher. In these cases, it needs the people at the top to be ethical, and whilst many are, but the potential conflict of interests between profit and spending on services remains problematic.

- **Registering new models.** New and emerging models of care and support do need to be registered, so our registering authority needs to be highly creative in establishing how. We suggest broadening the scope of regulated activities.
- **Registering more than providers.** Providers are registered, but that is all. We can see merit in considering the registration of other functions within the system, such as care management and commissioning. These services need to be populated by sound organisations and people with exemplary values, too.
- **Aligned partnership working.** As with Local Authority officers, CQC staff come and go. They drop in with their 'new' ideas, crack on with their implementation, and then leave, generally before it is delivered. It is the Provider community with sustains, and provides continuity in the Life Care sector.

  It should be obvious to all that Providers offer crucial insight, so we should be at the heart of whatever body oversees registration. This really is the only way to keep registration aligned with the needs of the Life Care sector and fit for purpose.

  Furthermore, the registering authority should be transparent in its workings, and open to consulting on planned projects before they are developed.
- **Efficient and effective processes.** There really is no excuse for the poor quality of many CQC processes. They just need fixing by someone who can design processes.
- **Who should be accountable for the registration process?** We have argued that the registering authority should work closely with Providers, but we also recognise that independence and objectivity are key. It is also important that the registration process is applied consistently across the country.

  We therefore see registration as an important national function, and see merit in it being carried out by a non-political commission such as the CQC. We take no issue with providers being charged reasonably for registration, but we do feel that Government funding should be maintained at an improved level. As noted, this process is vital if we are to have universally outstanding provision.

  We make one more controversial suggestion. At present we join registration and inspection together in the CQC vehicle. We can see arguments for maintaining this conjoined position, but also arguments for separation. Definitely worth the debate.

The Procurement and Contracting Process

Procurement is the process through which a purchasing body, usually a Local Authority or the NHS, buys services Life Care services on a person's behalf.

What characteristics should the Procurement and Contracting process have in a redesigned Life Care System?

A great Procurement and Contracting process would have these characteristics:

- **Refocus on quality.** We wish to see procurement practices re-focus on quality. In practice this means, for example, giving quality or service and delivery of positive outcomes greater weight in tendering processes, and ensuring that quality standards are maintained throughout the life of a contract.
- **Encouraging choice.** Placing people at the centre of their care and support is a key principle running through this paper. In procurement, this principle can be applied by maximising the choice that people have about their services. People should not just be steered to the option which financially suits the purchasing authority. We are attracted the idea of Procurement functions having approved lists of Providers rather than shortlists of the cheapest.
- **Fair Procurement practices and positive behaviours.** Procurement must ensure that its practices and behaviours are fair and balanced, even when the pressure is on.
- **Excellent national contracts.** There should be standard national contracts which fairly reflect the rights and obligations of the Purchaser and Provider. These should be produced independently and objectively, perhaps by the proposed the Care Funding Commission.
- **Standards.** We would like to see the introduction of a procurement code of conduct and a set of working standards.
- **Inspection.** As with Commissioning, we see merit in Procurement functions being inspected. This will ensure that conduct and standards are maintained, and promote good procurement practice.
- **Independent arbitration.** Where Providers come into conflict with Procurement functions there should be a fair and expedient arbitration process. This could be role for the newly constituted Health and Wellbeing Board.

Who should be accountable for the Procurement and Contracting process?

We see Procurement and Contracting as appropriate functions for the purchasing authority, whether the Local Authority or the NHS. However, these are public bodies, so they have a duty of care to society to ensure that their Procurement and Contracting functions operate well and fairly. It is for this reason that our recommendations both target an improvement in the quality of Procurement and Contracting standards, and propose greater scrutiny and transparency of their work.

The Inspection Process

Inspection is the process of review, or careful scrutiny. Its purpose is to ensure that specified standards are being maintained or exceeded, and drive action when they are not.

CQC sees its role as ensuring that health and social care services provide people with safe, effective, compassionate, high-quality care. They inspect services against criteria which they set and give a rating to indicate how services measure up against those standards.

We believe that it is appropriate for there to be an inspection function within the Life Care system. It is so important that high standards are maintained and promoted, because, as we know all too well, where services fail to meet the required standards, people suffer.

What characteristics should the inspection process have in a redesigned Life Care System?

Providers would like to see the following improvements in the inspection process:

- **Provider interviews.** Inspections would be significantly enhanced by interviewing the Provider. This feels like such an obvious thing to do, because gaining an understanding of proprietor's ethos, values, objectives, involvement, attitude to quality and shaping of culture is an excellent indicator of the quality of the service. In fact, we would go further – know the provider, and you know the service.

  Provider interviews are central to a risk-based approach to inspection.

- **Organisational inspections.** Good providers run good services. Where a provider has proven its values, leadership and quality over many years it is inefficient to inspect at unit or activity level. A smart and efficient organisational-level inspection would be an assurance of quality.

- **Inspecting in progressive models.** We note above that CQC is still hamstrung by the medical model, but Life Care is progressing, with social and developmental models that focus on quality of life outcomes. It will always be important to ensure people are being supported to be safe and healthy, but CQC needs to adapt to inspect and promote more progressive models. How well does the service support people to live a rich life? Do people live with real purpose? How are people supported to progress?

  Furthermore, we would wish to see our inspectorate actively promoting new and progressive models of care.

- **Support, help and advice.** Providers understand that it's inspectorate needs to be independent and that it will occasionally be called upon to take firm and decisive action. However, we believe that this is still possible within the context of a mature, professional and supportive relationship in which CQC is able to give help and advice. We are, after all, parts of the same Life Care system and we have shared objectives around service improvement.

- **Helping services with poor ratings and inspection on request.** We would wish to see CQC supporting providers with poor ratings by helping them build a route map back to a good rating. At present CQC merely ensures that an action plan is in place, rather than supporting its development. We would also wish to see a process of inspection on request so that providers who have made changes can see this reflected in their rating. This might be a paid service.

- **Utilising technology.** CQC needs to up its game so that it can inspect through the progressive IT systems being implemented by many providers. Much of this work could be done remotely, so visits can focus on interacting with people receiving support, proprietors, managers and staff.

Who should be accountable for the inspection process?

We have argued that the inspecting authority should work closely with Providers, but we also recognise that independence and objectivity are key. It is also important that the inspection process is applied consistently across the country. We therefore see inspection as an important national function, and see merit in it being carried out by a non-political commission such as the CQC. We have no issue with providers being charged reasonably for inspection, but we do feel that Government funding should be maintained at an improved level. If the inspecting authority is to play a more positive and progressive role than it needs to be resourced to do so.

C. Workforce requirements

It is a statement of the obvious that the quality of Life Care in the UK can only be as good as the quality of its workforce. In a very real sense, our sector is simply the sum of the people who work in it.

According to Skills for Care, in July 2020 there were 1.65 million jobs in the Life Care sector, making it larger than the NHS. The Skills for Care statistics also point to some of the major issues. Of the jobs total, only 1.52 million are filled, whilst forecasts suggest that a further 520,000 jobs will be required by 2035 as societal demographics evolve.

Building and maintaining a high-quality Life Care workforce is perhaps the biggest challenge facing our sector.

Characteristics of a great Life Care worker

Most people working in the sector directly deliver care and support, but there are a range of other roles too – managers, housekeepers, chefs, gardeners and other ancillary roles. What these roles all have in common is that they link directly to the quality of the experience received by a person accessing a care or support service.

The role of care and support worker is hugely challenging, and the people who do it well have outstanding skills, competencies and attributes. A great Life Care worker has:

- **Excellent personal values**
  Values have been high on the agenda for care and support providers for many years. Recruiting people with the right values ensures that people will be treated with kindness and respect. People with good values don't abuse.

  Desired values are well-known in our sector, and remain as important now as ever. The best Life Care workers are compassionate people who show respect to others. They have great personal integrity and are honest to a fault. They are passionate about doing right by those they support. They genuinely care.
- **Fortitude and resilience**
  Care and support work is not for the faint-hearted. Our staff are called on to show great resilience on many occasions, for example interacting with a person displaying challenging behaviour or consoling bereaved relatives. It's a tough gig.
- **Skills**
  Great care and support workers are highly skilled. Consider, for example, the communication skills required to reassure an anxious person with dementia, or to counsel a complex person with Asperger's syndrome. Unskilled work? We don't think so.
- **Energy and proactivity**
  It's hard work, but great care and support staff keep going. They give their all. They are energetic and proactive, knowing that they are changing lives every minute of every day.

Above all, great care and support workers are passionate about the wellbeing of those for whom they care and support. They empathise. They are the most human of humans. For many, it is vocation.

How many people do you know who fit the bill? Not many. And how many of those outstanding people are willing or able to do this skilled and challenging work for the National Minimum Wage? Significantly fewer.

No surprise, then, that our sector can't attract and retain a workforce of sufficient people of the right quality.

Current workforce issues

Providers highlight a range of issue which currently constrain their ability of build high quality workforces:

- **Public perception**
  There is nothing sexy about working in the Life Care sector. People just change pads, don't they? And isn't it the Social Care sector where all the abuse happens – Winterborne View, Whorlton Hall, etc? Not quite. Some brilliant staff go clubbing in Ibiza, supporting young people with learning disabilities to have a blast. Others hold the hand of a lonely older person as they slip away. All care and support work is about enriching peoples' lives. It is the most important and valuable of professions.
- **Perception vs the NHS**
  The NHS has it all. A wide variety of professional roles, delivering status, opportunity and reward. And all those benefits – job security, weeks of paid holidays, endless sick pay, fantastic pensions. How can our sector possibly compete with that?
- **It's seen as a job, not a career**
  Work in care and support is often just seen as a job. Something to fill a gap. Transient. Few people come into our sector because of the career opportunities they see.
- **Some aspects of the job are unattractive**
  The best care and support workers love to give care and support, but they are often frustrated by the burden of paperwork and administration.
- **Career opportunities are limited**
  The Life Care sector has many, many client-facing roles in which people directly deliver care and support. There are far fewer senior roles, so the pole is especially greasy.
- **Pay**
  Our society has underfunded Social Care for many years, facilitating an erosion of fees in real terms which has driven a pay race to the bottom. Increases in National Living Wage have now mopped up many in our sector, so our workforce is now bottom-crawling.

  There is a huge disconnect between the requirements of the roles in Life Care and the pay which providers can afford to pay. It is not sustainable and it is not fair. Great care and support workers deserve pay commensurate with the value they give.
- **Recruiting from the fringes**
  Low pay rates determine that Life Care can only attract people from those limited pools of people who will work for low pay – young people, retired people, people who earn a second wage, people from overseas.
- **Reducing immigration**
  Some of the very best care and support workers come from overseas. It has been argued that these people are prepared to do jobs that the Brits won't touch. This might have an element of truth, but the more positive rationale is that people from overseas seem to place greater value on those they support. Their lived experience of tight family and community extends into their work.
- **Investing in buildings, not people**
  The commercialisation of the sector has driven a focus on investment in buildings, not people. Buildings impress. But it is the work of people which really matters.

- **Providers not getting the basics right**
  Not everything is the fault of others. Life Care providers need the courage to look in the mirror. Do we do everything we could to attract and retain our staff? In Life Care we don't always get even the basics right. How many people don't have a plan to support their development? How many people don't have an appraisal?
- **A negative culture**
  The structure of the sector has created a negative culture in which little is celebrated but much is criticised. In particular, the behaviour of overstretched Social Services departments has become problematic. If anything goes wrong, let us point the finger at the provider.
- **Limited college or graduate recruitment**
  Most managers of care and support services started out as care and support workers. Many are outstanding. However, unlike other sectors, we tend not to recruit qualified people leaving colleges and universities. There will be outstanding people in these cohorts too, but we never see them.

This list is long, unstructured and incomplete, but it suggests that there is a raft of longstanding and deep-seated issues which prevent us building a high-quality Life Care workforce. We have already established that there is only a limited number of people with the attributes required to make a great care and support workers. If we now overlay these barriers, we start to see just how bleak our position is.

Ideas and solutions – How to make things better

Providers have identified a range of initiatives to enhance our ability to build a high-quality Life Care workforce. Many initiatives need to be driven by Government:

- **Registration**
  In recognition of the skilled nature of the role, we wish to see care and support work 'professionalised' through all available means. One helpful initiative would be to introduce registration of care and support workers. We see this as good thing. Registration would be a badge to wear with pride.
- **National Carer Wage**
  It is not fair or sustainable to pay care and support workers at or close to the National Minimum Wage. We would like to see the introduction of a National Care Wage, set at, say, £2 per hour above the National Living Wage. This would move the sector to move away from recruitment around the fringes to recruiting in centre too. Of course, this will need to be funded by commensurate increases in care and support fees.
- **Benefits**
  The Life Care Sector has been forced to restrict staff benefits. For example, it is now common for staff not to receive any sickness benefits. But we want to develop a high-quality workforce which sustains for the long term, so our staff need benefits which are equivalent to the NHS, not the gig economy.
- **Zero-hours contracts**
  The flexibility of zero-hours contracts works for some people, and it is right that people should have a choice. But for many they are a source of insecurity. People need to have proper terms and conditions to match the match the value we place on our outstanding staff.

- **Stop fee erosion**
  For many years, the Government has reduced funding to Local Authorities, so Social Services departments have responded by failing to increase fees in line with inflation. This inevitably drives pay down. It must stop. Care and support fees should be index-linked to break this dynamic.
- **Change public perceptions**
  There is much work to do to change the negative public perception of care and support work. This requires action to be taken in many of the ways outlined in this report, and for work in Life Care to be promoted effectively though marketing and PR.
- **Careers**
  We need to think radically about careers in care and support. The traditional pathway is from care and support worker, to senior, to deputy manager, to manage, but there are so many other pathways that people can follow, for example into specialist roles, or social work, or into health roles. Innovative career pathways could also take place between organisations and between different sectors within the Life Care sector. Pathways need to be set out clearly and made accessible to people who might consider a career in care.
- **Careers Services**
  We need to reach a point where Careers Services in schools, job centres and elsewhere promote working care and support as a positive career choice to people. To reach this point, we need to make sure that there is genuinely a positive career choice to be made, which means fixing everything else on this list.
- **Opening channels**
  As noted, our sector currently recruits from the fringes. We wish to be able to recruit from the centre too. Wherever we recruit from, however, we need to ensure that recruitment channels are wide open. People should able to enter the Life Care workforce through smooth and speedy processes. The quality, of course, must remain high.
- **Attracting young people**
  We cannot overstate the importance of attracting young people to work in the Life Care sector. Our objective should be to reach every school-leaver so that they are clear about the merits of working in the sector. To do that we need to pull all the levers – engage with careers services, use social media, link Providers to schools and colleges, sell the benefits.

  Beyond this we would like the Government to put more funding into work placements and apprenticeships. Funding these in entirety will motivate employers and attract people into the sector.
- **Attracting older people**
  Young people are essential. Older people are a bonus. The bring their life experiences, caring natures and maturity to care and support work. These days, many people take early retirement, or seek out ways to rebalance their lives. We need to find a way to reach them and draw them in.
- **Workers from overseas**
  Our immigration policy is erecting barriers and damaging a Life Care System which relies on outstanding people coming from overseas. We should do the opposite, and provide easy channels through which people can come from overseas to work in our sector. We should also give people long-term certainty and security of tenure.

- **Graduate management recruitment, training and development**
  Care and support services are only as good as their managers. Some excellent people progress within the life care sector, but we would also wish to see people enter our sector from further and higher education. We would like to see the introduction of a government-sponsored management training programme to provide an attractive pathway through which people will enter our sector. (We note that Skills for Care have recently cancelled their graduate training programme, but also note that only one of our number knew of its existence.)
- **Manager qualification**
  The Registered Managers Award, linked to the NVQ structure, was withdrawn in 2017. But we see an important role for a respected and portable manager qualification. This is part of the professionalisation of care and support work.
- **Manager training and development**
  The NVQ structure is not without merit, but as providers we are concerned that it doesn't develop some of the skills required by managers if they are to be truly excellent. Our paper hints at these things – how to be a great leader, how to develop an outstanding service, the importance of role-modelling exemplary behaviour, how to develop a supportive culture based on mutual respect, how to recognise your staff. These are examples of subjects which should be salient in management training.

  We would also argue that management training should be ongoing. Many professional roles have continuous professional development requirements, and these should exist for managers in the Life Care System too. Our environment constantly evolves, with new practices, processes, technology and regulation. Managers need to be on top of all this. At present, only those who are self-starting, or working in supportive organisations, will stay up-to-date.
- **Investment in people**
  We note above the requirement for a minimum carer wage, but we see the imperative for investing in staff as more than this. We see it as a requirement for a cultural shift to a position where people working in the Life Care system will work with an assurance that are being invested in, whether through pay, other benefits, training and development or any other means. Investment is a mark of value.
- **Technology**
  We see technology as an enabler with the potential to reduce the number of care and support staff required. To be clear at the outset, nothing can replace human interaction, but there may be ways to free up care and support worker time to focus on what they should be doing. There are some innovative care management systems which enable care notes to be recorded quickly and simply without resorting to writing a report. There are also some good monitoring applications on the market, and we can see how digital technology can play an increasing role in communications, social networking, and access to data and information.
- **Promoting independence**
  We hold to the view that, by-and-large, people don't really want to be on the receiving end of care and support. How disempowering is it to have someone, possibly a stranger, delivering personal care? How intrusive is it to be compelled to have someone with you all the time? Many younger adults with learning disabilities could live more independently, with less support. We need all services to be progressive, not static, we need mechanisms to support people to aspire and develop, and we need pathways for people to follow. Fewer hours, but better hours.

- **New roles**
  This paper alludes to new and innovative models of care and support. In these emerging models, and others, the roles within our sector will change. This provides an exciting opportunity to re-frame the offering to people with the qualities to work in the Life Care sector. In progressive learning disability services, for example, we need our staff to be enablers and educators, and to be recognised and rewarded as such.

  Other initiatives can be taken by the sector itself:

  – **Make the role more attractive.** Our sector should think strategically about how to make roles more attractive. For care and support workers, this should include finding ways to reduce administration.

  – **Treat people well.** Staff retention in our sector is generally poor, with turnover rates reported to be over 30%. But some organisations do significantly better. They tend to be the organisations with principled leadership, and positive and respectful cultures.

  – **Recognise people.** An important aspect of treating people well is to recognise and value their work. People relish working in positive cultures, but dislike working in cultures rife with blame and criticism.

Summary

The sheer scale of the workforce issue is overwhelming. It feels hopeless, an unconquerable mountain of a problem.

But it isn't. We know the solutions and they are attainable. All we need is outstanding planning and implementation at Government level and real long-term commitment, backed up with increased resources.

Without this, we face a very difficult future.

Appendix I –
Failings in existing Social Care processes

FAILINGS IN CURRENT INDIVIDUAL EPISODE PROCESSES

Failings of the current Assessment process

We observe several failings with the current assessment process, notably in respect of the way assessments are carried out and by whom:

- **Focus on the medical model**
  Assessment processes tend to follow the medical model, with its emphasis on the basics we need to stay alive. The process tends to pay less attention to people's higher-order social, developmental and psychological aspirations.
- **Conflict of interests**
  The Care Act 2014 gives Local Authorities the accountability for undertaking assessments, but these bodies are also responsible for funding care and support to meet people's eligible needs. This is a clear conflict of interest.

  When the functions of assessor and commissioner co-exist, there is a risk that commissioning pressures are prioritised. Instead, assessment and commissioning structures should work in partnership but remain separate entities, ensuring that the best possible outcome can be guaranteed for the individual.
- **Eligibility criteria**
  The Care Act 2014 included a national eligibility framework, but each Local Authority determines the level of need at which they will fund services. In some areas people with moderate needs still receive funded services, whilst in other areas peoples' needs must be substantial, or even critical, before they are entitled to receive state-funded care and support.
- **Role clarity**
  The Care Act 2014 determines that assessment is a process owned by the Local Authority. Providers would argue that their assessment processes are equally important, because they also have to decide whether they can deliver a service which meets the person's need and aspirations. Providers would also argue that their assessment processes are of better quality because of the specialist nature of their assessors.
- **Duplication**
  In some cases, people are subject to repeated assessments, firstly by the Local Authority and then by a range of potential service Providers.

Failings of the current Placement process

The current placement process has several failings:

- **Lack of choice**
  The Care Act 2014 states that the Local Authority must 'help the adult with how to have the needs met'. But this suggests a degree of choice and control which is absent in the current process. People often have little choice about where they are placed.
- **Misplaced emphasis**
  S.30 of the Care Act 2014 includes provisions for the circumstances where a person expresses a preference for particular accommodation. The section reads like it is drafted to facilitate an exception, when choice of accommodation really should be the norm.
- **Care planning confusion**
  The Care Act gives accountability for production of a Care Plan to the Local Authority. This then (theoretically) becomes one of the bases on which a placement is selected. However, Providers will often develop their own Care Plans based on their assessment and agree this with the individual.
- **Lack of guidance**
  Where people and their families or advocates, do play a role in choosing, they often lack to knowledge about how to go about it.
- **Market insight**
  If you are a lay-person looking for a care service, where do you start? There is no national register of care providers.
- **Patchy and inconsistent Provider information**
  There is some standard information produced by Providers (such as the Statement of Purpose), but the quality and form of information produced varies widely. People choose services based on patchy and piecemeal information.

Failings of the current Service Delivery process

As providers, we can state with certainty that there is some excellent care and support in Surrey, and we are pretty sure there is good provision beyond our borders too! We also recognise, however, that care and support provision is not always of the right quality, and observe some systemic structural failings within the system:

- **Poor quality provision**
  In any market there will be operators who perform well and others who do not. The 2019 State of Care Report, the CQC notes that 1% of services inspected were rated as 'Inadequate' whilst a further 15% were rated as 'Requires Improvement'. This is too many.
- **Unethical provision**
  Some providers operate with profit as their primary motive, and will compromise on quality if it supports the achievement of that objective. (Note, however, that we do not see profit as a dirty word. It is entirely fair for people who take financial risks and build care organisations to receive fair financial returns, just not at the cost of quality.)
- **Investment funding**
  Provision of care and support is attractive to external investors. It is often property-backed, underwritten by a state-funded revenue stream and supported by positive demographic trends. It is seen as a safe haven in comparison with other more-volatile sectors.

  There are three issues relating to institutional investment in the Life Care sector:

  1. Institutional investors are generally interested primarily in the financial return they will make. Some do also have humanitarian and ethical objectives, and some see a link between quality and value.
  2. There is often a disconnect between the investor and the provider organisation. Few American investors in Real Estate Investment Trust will even know which care and support organisation they are backing.
  3. Institutional investors generally want to 'turn' their investments every 5-7 years, being the period in which they can most rapidly grow profits and earnings-multiples. This drives short-term strategies which can work against the best interest of people accessing services, create inherent instability and mitigate against long-term consistency.

- **State provision**
  Whilst there is some good quality State provision of care and support, history tells us that the State provision is not the best model. We see two problems with State-delivered care and support:

  1. Managers in Local Authorities and the NHS come and go, so policies and management are inconsistent. There is no long term 'skin-in-the-game'.
  2. Innovation and creativity can be less-evident.

- **Poor models**
  The economic realities of our sector have shaped model design in a way which is not always beneficial for the people they support. Older-peoples' services are built ever-larger, but CQC reports tell us that smaller, owner-managed services provide the best care. In the learning disability sector people, there are still many registered services for 5 or 6 people, but who would choose to live with five other people? The number is driven by the need for providers to achieve economies of scale, rather than the best interest of the people who live in those services.

- **Imperfect market**
  As indicated in respect of the Choosing process, there are several ways in which the market does not function well. People do not understand the choices available or have the ability to make those choices. Often, people do not know what good looks like.

Failings of the current Review process

The current review process has several failings:

- **Fundamental problems**
  There are some fundamental, intrinsic problems with the notion of a review process:

  – It is intrusive.
  – It tramples on peoples' rights. What right does one adult really have to measure the progress or critique the failings of another?

- **Ownership**
  The Care Act 2014 gives accountability for the review process to the Local Authority. We see this as paternalistic, and wish to see accountability shifted to the individual.

- **Focus**
  In the current financial climate, the focus of Local Authorities is often on cost rather than quality.

- **Content**
  The content of the review tends to be determined by the Local Authority or the provider organisation. It is seldom set by the person who is the subject of the review.

- **Negativity**
  Reviews often focus on what has not worked well, rather than celebrating what has.

- **Medical model**
  In common with the assessment process, the review process also tends to focus on basic needs, such as health and nutrition.

- **Attendance and participation**
  The subject of the review seldom gets to choose who attends. Their life is often played out in from of people they don't know.

FAILINGS IN CURRENT MARKET MANAGEMENT PROCESSES

Failings of the current Policy-setting process

We note the following failures of the Policy-setting process:

- **The poor state of the sector**
  In this report we have been critical of many aspects of the Life Care sector. We see it as broken in many ways, and we have watched it deteriorate over many years. This is unequivocal evidence of the failure of policy implementation, and a strong indicator of the failure of the Policy-setting process too.

- **No place on the agenda**
  Life Care is currently high on the Government's agenda. Even prior to the Covid-19 epidemic, there was a manifesto pledge to reform the Life Care system, and recent events have amplified the need for change. It has not always been the case. Whereas the NHS is always at the top of the agenda, Life Care is frequently overlooked.

- **What is the problem?**
  As Providers, we understand the issues and problems in the Life Care system, but we are not certain that these have been articulated at Government level. Without understanding how and why something is broken, you have no hope of fixing it.

- **False starts**
  Over the past twenty years there have been several valiant attempts to set policies designed to re-shape our sector, but they have all stumbled.

- **Unclear accountabilities**
  Who is really accountable for policy at national and local levels?

- **Disconnect between policy-setting and implementation**
  The policy-setting which has gone on at Government-level is generally well-intentioned and often insightful, but little has been implemented. Why is this?

- **Local fragmentation**
  We see policy-setting at local level as a mixed bag. At times, policies set by Local Authorities are clear, but often they are not. Policy-setting processes, such as they are, are opaque and fragmented.

- **Inconsistent**
  At local level, policies change with the wind. Every new Councilor and Director comes in with their ideas, shapes policy in their image, sets up a programme and then leaves before anything is implemented. We Providers keep a healthy distance, and continue do what we think is right.

- **Short-termist**
  Local Authorities are woefully underfunded, so their whole attention is focused how to balance the budget in the current financial year.

Failings of the current Commissioning process

Providers observe a number of failings with Commissioning processes. Note that whilst we are Surrey providers, many of us also contract with other Local Authorities too, so our observations are not specific to Surrey (although some are!):

- **Ineffective**
  Commissioning functions are sometimes just not good at doing what they are supposed to do. In Surrey, for example:
  - There has never been a Learning Disability Market Position Statement, despite this important signposting tool being specified as a requirement in the Care Act 2014.
  - We have not seen a Joint Strategic Needs Assessment for several years.
  - The current strategy in Surrey to develop hundreds of independent living units for people with disabilities has not been properly consulted on and (we believe) may not match the assessed needs of the population.

  Perhaps the worst recent example, however, was Hampshire's initiative to re-shape its Domiciliary Care market. It essentially closed down small local providers and gave large contracts to a few big companies, some based over 200 miles away. They failed to deliver. Services collapsed and the market imploded.
- **Variable quality**
  Talk to any Provider and they will tell you that they have dealt with good and bad Commissioners. Quality is highly variable. We wonder why this is? Perhaps it is the rather nebulous nature of the function, or the fact that many people who operate within it have not.
- **Financial constraints**
  Commissioners are often hamstrung by the financial constraints placed upon them. They often appear to be subject to top down process of being told how big their financial envelope is, rather than this being a bottom-up process based on the needs of the population. This inevitably leads to quality being compromised. An example of this is the Surrey brokerage model for Domiciliary Care, which appears to allocates work solely on the basis of price. This pervades into the culture, making Providers feel undervalued for the quality of their work.
- **Lack of creativity**
  Commissioning functions appear to lack creativity. There have been some good creative and innovative ideas in this area, but they are seldom picked up operationally. Where is the outcome-based commissioning in practice? Who is rolling out models which facilitate up-front investment in people to promote interdependence and deliver downstream savings?
- **Lack of communication**
  Some Commissioning functions seldom communicate with Providers. They stay in their ivory towers.
- **Poor relationship management**
  We see relationship management as an important part of the Commissioning function. It is the way for Commissioners to gain market insights and to exert influence and signpost to shape the market. It is often absent. In addition, there is lack of forward planning in commissioning structures – a failure to look ahead and plan for future need.

- **Commissioning behaviour**
  The behaviour of Commissioning functions is sometimes parent-child in its nature. There is a power imbalance which is sometime exploited.
- **Link to Procurement**
  Commissioning and Procurement functions are often conjoined, but we see them fulfilling very different functions.
- **Not inspected**
  Commissioning functions are not inspected. We believe that if they were, the results would be startling. It would highlight the variations between Local Authorities and the poor quality if some Commissioning functions.

Failings of the current Registration process

Go back twenty or thirty years and the models of care and support where much more clearly defined than they are now. Essentially, there was a place-based residential care model and a domiciliary care model delivering services to people in their own homes. In many ways, these straightforward models were relatively easy to register.

Roll forward to the present and we see a more complex picture. Models of care and support have become fluid as they have sought to match peoples' needs and wants and give people more control over their lives. So, we now have a plethora of models, such as supported living, extra-care and shared lives, with new variations evolving all the time.

This dynamic must be a nightmare for the Care Quality Commission. With every new model comes the challenge of how to register it. This difficulty sits at the heart of many of the issues raised by Providers.

Surrey Providers have expressed the following concerns:

- **Bar set too low**
  Put bluntly, there exists a small minority of poor services led by people who are not fit, often operating with profit as a primary motive. These providers should not have been registered in the first place.
- **Registering the wrong thing**
  Accommodation has always played a disproportionate role in registration. Remember the days of measuring rooms? Does it include the built-in wardrobe? What about the en suite? Accommodation is important, but really it is of nothing compared to the values and ethos of the person who owns and operates the service.
- **Registering Supported Living, Shared Lives and Live-in Care**
  The registration of supported living services is not fit for purpose. At present, providers are essentially registered to carry out regulated activities. For supported living services, the most common regulated activity is that of delivering personal care. However, where this activity is not present, then the service can go unregistered and unregulated, which presents some risk. We are aware that CQC are currently wrestling with this issue.

  Whilst some activities are regulated in supported living, there is no registration of shared lives services whatsoever. Quality monitoring falls to the Local Authority, and will be done through a hundred locally-developed processes to varying degrees of success.

  Similarly, live-in care goes unregistered, at least in part. Agencies who set up to source live-in carers to people do not carry out a regulated activity, so do not have to register. This creates a risk that an unsuitable person might be placed into a highly intimate relationship in which abuse could go unseen.

- **Misaligned policy**
  The Care Quality Commission determines policy in a way which is not always aligned with the views of providers. An example would be the CQC view about the size of learning disability services which it will regulate. Again, we know that this is an area in which CQC is striving to give greater clarity.
- **Non-consultation**
  CQC has historically been closed to consultation about the development of new services, loathe to comment on the registerability of services prior to development.
- **Accountability**
  It is not clear to Providers who the CQC is accountable to. As Government funding is reduced and provider funding increases, we definitely perceive that CQC need to deliver greater value. However, it is a pre-requisite that the regulator has to be independent, so there is a growing conflict of interest.
- **Horrible processes**
  The paucity of some of the current CQC processes has to be experienced to be believed. We challenge you to find a provider who does not have a tale of woe. Particular problems have occurred where there has been a transfer of ownership, where services re-registered, where registered managers have been de-registered, and where services have closed. So much rework. So much frustration. So much inefficiency. So much waste.

Failings of the current Procurement and Contracting process

In Surrey, Providers have been on the receiving end of a catalogue of poor procurement practices. We can cite lots of bad examples, and only one good. We see the failings as:

- **Focus on money, not quality**
  In these financially constrained times procurement practices have focused on saving money by buying cheaply. Quality is taking a back seat.
- **Closing down choice**
  The publicly-funded Social Care market is unlike other markets because the person receiving the service is not paying for it. So, who is the customer? There is a disconnect here which can be problematic. The matter of choice provides an example. People would want to exercise choice of service, and this is embodied in the Care Act 2014. Procurement functions, however, often close down choice to secure the cheapest option.
- **Procurement behaviour and culture**
  We have experienced occasions when Procurement functions have been overly directive. This perhaps reflects the unequal nature of the Procurement/ Provider relationship, and tends to especially when financial constraints are tight.
- **M&S supply chain management**
  Every so often someone comes into a senior position from an FMCG background and attempts to introduce hard-nosed commercial practices into our sector. We have experience of strategies aiming to reduce the number of suppliers to a 'manageable' number. We have suffered enforced in-year rebates and volume discounts. This is the antithesis of partnership working, creating conflict and dissonance. It is entirely counter-productive.
- **Failure to understand the true cost of care**
  Despite clear data, we have seen procurement functions push to introduce rates which are below the costs of care.
- **Fee rigidity**
  It is almost impossible to secure a change of fee for a spot contract, even when there is a change in need.

- **Imposed changes**
  Changes in fee levels and procurement procedures are often simply imposed on the market.
- **Poor quality, biased contracts**
  We have contracts which are not fit for purpose. They are poorly produced, cobbled together from others, and do not fairly balance the rights and obligations of each party. Rather they reflect the imbalance in the relationship between purchaser and Provider.
- **Contract wheel reinvention**
  Every Local Authority produces its own contracts. There is no standardisation and the quality varies. This is inefficient and wasteful.

Failings of the current Inspection process

We do not see the inspection system as fundamentally broken. Indeed, there are some aspects of the current inspection system that Providers like. Reports are generally fair, the rating system is clear and much useful information is provided to the reader.

That said, we have identified some concerns which need to be addressed:

- **Support and reinspection following a poor rating**
  A 'Requires Improvement' or 'Inadequate' rating effects everything, potentially driving a downward spiral in which reputation falters, occupancy decreases, staff go elsewhere, and profits turn to losses. It becomes as self-fulfilling prophecy. At present, providers receive scant support from CQC to improve, and often have to wait many months or even years for a reinspection. This is particularly harsh where the poor rating was down to a simple human error or a technicality.
- **Inconsistency**
  There are significant variations between the approaches, behaviour and judgements of inspectors.
- **Providers are not part of the process**
  Providers are generally not interviewed as part of the inspection process. This is a remarkable omission given the role that they play in shaping the culture and quality of their organisation.
- **Inspections are granular, even when low risk**
  Inspections take place at unit or activity level, but this is highly inefficient. There are better ways to inspect providers who have proven themselves over many years.
- **Paranoia about getting too close**
  The CQC appears to be concerned that inspectors might develop close relationships with providers and lose their objectivity. Providers, however, argue that a close and mature professional relationship enhances CQC's ability to inspect effectively.
- **Approach to giving advice**
  It is interesting to note that CQC's Statement of Purpose states that they seek to encourage services to improve. Over recent years Providers have not seen this in practice. We do, however, detect a slight change – CQC seems to be starting to engage more positively with the sector.
- **The medical model**
  Inspections still focus heavily on medical approaches. Are people being fed and watered? Is medication being administered properly? Are people safe from harm? But in many progressive services these are now a given, they have become hygiene factors. Life Care is moving on. Providers are focusing on how to support people to live enriched lives of real purpose. But CQC hasn't caught up, so there is a mismatch.

This point goes to the knub of what great Life Care is about. Of course, it is important to ensure people are safe and well, but life is about so much more.

- **Not IT savvy**
  Providers are forging ahead with technology in their organisations. Many now have automated care management systems, some recording through voice or hand-held devices. Some have additional quality management and compliance systems. CQC are not making use of these systems to improve the quality and efficiency of inspections.
- **No registration, no inspection**
  The issues highlighted in relation to areas of the Life Care sector which are not being registered flow though to inspection, since a service which is not registered is not being inspected. Examples are live in care, shared lives and supported living (where there no regulated activity).
- **Accountability**
  Is CQC accountable to the Provider community? Providers would certainly wish this to be the case given that they are funding an ever-larger proportion of CQC costs.

Appendix II – Innovative Service Models

Much of the innovation in the Life Care sector comes from Providers. This is only to be expected – Providers have had to be creative, innovative and resilient to survive.

Here, we set out some of the innovative work being done by Surrey providers. You would find other examples the length and breadth of the country. We are concerned, however, that the Life Care system is not good at picking up on these kinds of innovative ideas, supporting their development and rolling them out across the system. Whilst Providers pay great attention to developing learning cultures within their own organisations, we do have a learning culture within the Life Care sector as a whole.

The Virtual Care Home

The Virtual Care Home is an innovative model where people are discharged back to their own homes with a domiciliary care package but where wrap-around support is provided by a care home. It was developed by Simon Whalley of Birtley House, a long-standing high-quality provider of services to people in West Surrey.

The model has the following characteristics:

- When ready to go home a person's use of a domiciliary service is essential.
- It needs to be fully interactive with the Care Home at two levels:
  - Medical Level – proactive engagement of GPs.
  - Social Level (very important) as patients feel that they still belong and are not isolated, e.g. they can continue to enjoy social activities provided by the Care Home on a 'Day Club' basis and have the opportunity to interact with their friends in the Care Home by Skype or similar social media.
- The Domiciliary Service is alert to any changes in the condition of the patient(s). This might also be picked up at Day Club so that if their condition deteriorates, it can be picked up early and treated, enabling them to return to the Care Home, rather than go back into hospital, for treatment at lower room cost, much smaller admission costs, less risk of cross-infection and more sociable environment leading to faster recovery and return home.
- Community Matrons and Nurses in GP practices need to be engaged in the process.
- A joined-up IT system that works will be key to success with interactive TV to enable remote interaction with Specialists, GPs, ancillary services, carers, families and friends.
- Domiciliary Services and GPs need to be alert enough to transfer patient to Care Home rather than hospital in the event of regression or other deterioration in mental or physical well-being.

The financial benefits of the Virtual Care home are potentially huge:

- Taking a 6 week stay in hospital @ £4,000 per week = £24,000
- The core costs of the Virtual Care Home (VCH) proposal for the same period should approximate to the following:

  Say 3 weeks @ £1,700 for Care Home costs = £5,100

  3 weeks @ 28 hours pw Home Care x £25 = £2,100

  3 weeks x £30 Day Club twice weekly = £180

  Total Costs in this period = £7,380

  Overall Saving = £16,620

Note: If the VCH costs were allocated 66% NHS and 34% Adult Social Care the costs would be: £4,871 NHS and £2,509 Adult Social Services.

Additional savings with reduced use of Hospital staff and specialists – though additional input from Community nursing and GPs.

The Big Life Adventure

Everyone deserves to live a life of real purpose. A life filled with possibilities. With space to be curious and the freedom to achieve.

Introducing The Big Life Adventure. Peak 15 (a new name for Ashcroft Care Services) has been working on a new planning framework for people with learning disabilities for two years. Co-designed by people with disabilities, it enables people to make the most of the rich opportunities that life presents.

The Big Life Adventure is designed to revolutionise the way people with learning disabilities think about their lives. In most cases, Social Care only meets a person's basic care needs, such as accommodation, food and safety. And people with disabilities have low expectations about what they can achieve in their lives. People rarely have meaningful relationships or choose who they live with. Few share their home with a loved one, have security of tenure, or have a job. Across all areas of life, there are striking differences between what is achieved by people with learning disabilities and other citizens.

The Big Life Adventure is designed to change that. It enables people to explore their real wants and desires – to question the status quo, build on their strengths and fulfil their potential. It is a paradigm shift in thinking which will enable people to lead enriched and unlimited lives with real purpose.

The Big Life Adventure sees personal growth as the kitbag for the journey. The development of life skills, self-sufficiency, physical well-being and spiritual well-being enables people to follow the paths they choose. This personal growth then helps people to focus in on other key areas of life – things that are important and matter to everyone – like our relationships, our work, our interests and activities, our home and taking a break. Everyone should have the freedom to explore and grow in all these different areas of life. It should be no different for people with learning disabilities.

But someone with a learning disability might never have been asked to challenge any preconceptions or low expectations that they, their families, their support workers or the wider community have about what is possible. And whilst they may feel totally happy with some areas of their life, they might feel disappointed, disillusioned or dissatisfied with others. This is where the Big Life Adventure comes in. Every person's adventure will be a unique journey, wholly individual and person-led.

It starts with a conversation. A conversation that helps people identify what would change their life for the better – to understand and question the status quo, explore the possible and articulate long-term aspirations. The Big Life Adventure will map the journey and support personal development in ways that have not been considered before by challenging assumptions and promoting positive risk-taking.

It will require support from outstanding and highly trained – people trained to look beyond the outcome or the result. And in time greater self-sufficiency will lead to a long-term reduction in support hours – a great outcome for the adventurer as well and the care system as a whole. Through challenging existing norms and collaborating across the sector, The Big Life Adventure gives everyone the opportunity to lead a life rich in purpose. The Big Life Adventure is a journey, a way of life.

Accessible Day Services

It is widely acknowledged that to enjoy a hobby or develop additional skills outside of our daily nine-to-five is immensely beneficial for our mental health. Regardless of people's circumstances and daily routines, participating in stimulating activities and gaining pleasure from interests is important to our wellbeing. This is no different for adults with a learning disability.

Recognising the needs for person-centred activities, Dayspace has been running a weekly programme of creative and practical sessions for adults with a learning disability in Surrey since 2011. More recently, in order to connect people during lockdown and beyond, Dayspace is now offering a timetable of online interactive sessions via Zoom. Despite some negativity around how adults with a learning disability will engage in sessions online, care providers have been pleasantly surprised with the overall engagement rate and the fact that some clients have learned to operate some aspects of Zoom themselves e.g. join/leave and mute/unmute actions is extremely encouraging.

In addition to providing existing session activities online and inspired by the need to drag social care into the 21st century, Dayspace has also invested in developing new sessions.

Today's reality dictates that many actions we take on a daily basis involve some form of technology. Owning a smart phone and/or tablet has become commonplace and knowing how these devices, apps, editing tools etc work could now be described as life skills. Not all adults with a learning disability own a smart device, but most have (or should have) access to them, but still require the skills to operate them independently and discover the full extent of what the devices can be used for.

Always pushing the boundaries to enable clients to shine, Dayspace is now offering sessions which involve teaching digital skills and e-safety. These sessions can be adapted to the skills the clients want to learn and the latest example of this is Dayspace Radio which broadcasts every week and is planned and presented by clients. There is also a Dayspace Podcast that was started by Dayspace staff during lockdown and has now been taken over by our clients. The highly experienced staff team, whose careers have seen them work as professional musicians and actors in West End theatres and in roles involving social media, are perfectly placed to pass on the knowledge and skills they have acquired to create a fun-filled skills-based session.

Learning how to use mainstream technology safely is a key element in maintaining independence and Dayspace recognise the importance of this for adults with a learning disability and their future.


Surrey Care Association
Supporting Social Care Providers in Surrey
surreycare.org.uk