Number: WG42832

Welsh Government

Consultation – summary of response

Rebalancing care and support

A consultation on improving social care arrangements and strengthening partnership working to better support people's well-being.

29 June 2021

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Contents

Summary of responses

In total, 155 responses were received to the White Paper consultation, with nearly three quarters of responses made up from local government and the third sector. Generally respondents called for greater clarity on proposals and respondents felt they needed more information to answer the consultation question. There was an overwhelming commitment to working with Welsh Government to develop policy proposals further, to support the achievement of vision for social care, set out in the Social Services and Well-being (Wales) Act 2014.

There was a majority agreement in relation to consultation questions on:

- The complexity in the social care sector inhibiting service improvement;
- Commissioning practices being disproportionately focussed on procurement;
- The use of real-time population, outcome measures and market information to more frequently to analyse needs and service provision; and
- Needing further change to address the challenges highlighted in the case for change.

The majority of respondents recognised the challenges set out in the case for change and agreed on the proposals for a system that is more simplified, focused on quality and social value, led strategically not reactively, outcomes based and rooted in partnership and integrated working focused on people's outcomes. Many responses thought the impact of the proposed reforms on people, their well-being and rights needed further consideration. However responses to the remaining questions tended to be more contrary, with no clear majority view. A significant number of respondents chose not to state whether they agreed or disagreed with questions, however provided detailed narrative text of their views.

Mostly it was thought that a national framework would be beneficial, if it was defined clearly, reduced complexity and enabled local decision-making. Providers in particular welcomed the potential for the reduction of complexity and removal of duplication or waste, particularly when services are provided in more than one local authority area. In addition, an increased focus on commissioning by quality, outcomes, rights and well-being was welcomed. Moreover many responses noted the benefits of a framework as encouraging and facilitating integration and joint commissioning. It was noted that any national framework should align to the whole system values described in 'A Healthier Wales', focussed on co-ordinating health and social care services seamlessly, describing evidence based models of care at a national level, which is then implemented to meet local population needs. Respondents felt the there was much to learn from existing efforts to standardise commissioning practices in the social care sector. In general those who did not agree with this question believed a national framework would be inflexible, at the expense of local autonomy. The importance of local circumstances was highlighted and the ability of organisations to define and secure provision in a way that meets their own priorities.

A range of interpretations about the purpose of a national office were provided. Those that were in favour of an office, thought activities of some existing national groups should be consolidated where there is added value, such as to reduce duplication, pool resource and to enable greater effectiveness and efficiently. Most

responses from local government did not support any structural change and called for formalising existing structures or establishing a national office in government to reduce bureaucracy. Others thought a national office needed to be independent of government in order to hold respective statutory partners to account and build relationships with the market. Those that chose to neither agree nor disagree thought they needed more detail on the remit of a national office and which existing national groups were being considered and warned of additional layers of bureaucracy, and would generate confusion about roles and responsibilities with other organisations.

The majority of respondents that thought Regional Partnership Boards' (RPBs) ability to deliver on their responsibilities is limited by their design and structure were from the third and independent sector and from citizens. Many of these responses cited challenges in RPBs implementing current functions effectively (in relation to transparency, accountability, co-production and measuring outcomes and impact). There were calls for a formal review of their structure, membership and how they are formed currently as part of any future reform. Conversely, statutory bodies felt existing legislative provisions to support integration and pooled budgets were already sufficient to enable RPBs to undertake their existing responsibilities. Many responses thought creating another legal entity would create unnecessary bureaucracy and complexity, particularly for commissioners. The relationship between integration at a local and regional level was highlighted by many responses, including the importance of planning and delivering services as close to local populations as possible. Some highlighted the continued improvements made by RPBs and instead called for strengthening of existing arrangements.

Specific consultation questions were asked in relation to the Welsh Language. A number of responses cited difficulties in providing Welsh language services at a local level and the challenges RPBs currently face in relation to existing Welsh language duties. There was a consensus that Welsh language must be at the core of further policy development, that materials should be produced bilingually and that any new body should be required to comply with the Welsh Language standards.

Introduction

Background

The Welsh Government published a White Paper, Rebalancing Care and Support on 12 January 2021 for a 12-week public consultation[1], which closed on 6 April. The consultation asked about proposals to introduce legislation and policy to rebalance care and support to achieve the vision set out in the Social Services and Well-being (Wales) Act 2014.

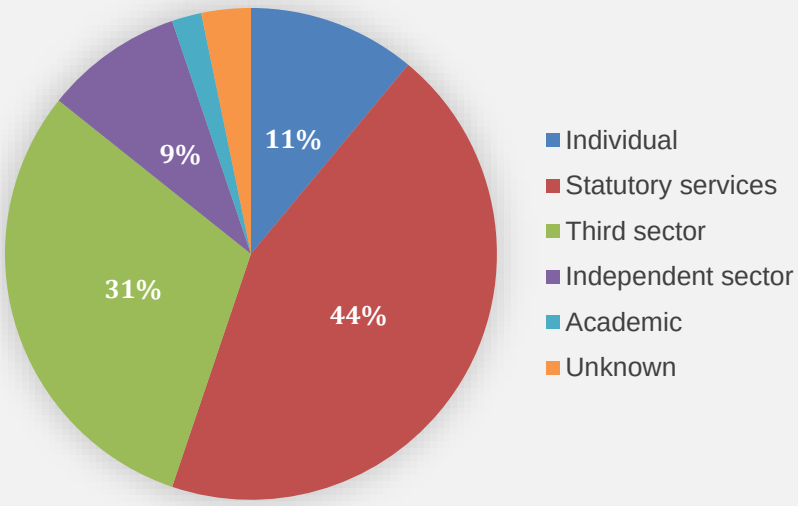
Rebalancing means…

…Away from complexity. Towards simplification.
Away from price. Towards quality and social value.
Away from reactive commissioning. Towards managing the market.
Away from task-based practice. Towards an outcome-based practice.
Away from an organisational focus. Towards more effective partnership…

… to co-produce better outcomes with people.

The list of respondents is provided at Annex A, with anonymity protected where requested. In total, 155 responses were received to the White Paper consultation. This document summarises those responses. The breakdown of responses by sector are provided in Figure 1.

Figure 1: Breakdown of responses by sector



Respondents were asked whether they agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with the consultation questions.

[1] Rebalancing Care and Support White Paper consultation

Respondents who chose not to state whether they agreed, disagreed or tended to neither agree or disagree with questions, have not been included in the data provided in Figures 2-10 in this document.

Throughout the responses, a number of core themes were identified, listed below:

- Outcomes
- Co-production
- Advocacy
- Social value
- Culture and leadership
- Welsh language
- Funding
- Direct payments
- Procurement legislation
- Workforce.

Views against these themes are embedded within the summary of responses for each consultation question and addressed specifically under the section 'Question 9 and 13' collectively.

Engagement

In advance of the publication of the consultation, the Welsh Government underook pre-consultation discussions. A Welsh Government reference group was established with representation from the public sector (through the Welsh Local Government Association (WLGA), the Association of Directors of Social Services Cymru (ADSSC), the NHS Confederation, Social Care Wales), the third sector (through WCVA) and the independent sector (through Care Forum Wales/ National Provider Forum). Official level discussions also took place with the National Collaborative Commissioning Unit, the Children's Commissioning Consortia Cymru (4Cs) and the National Commissioning Board.

The Deputy Minister for Social Services chaired a Ministerial Reference Group with membership from HEIW, WLGA and local authority Cabinet Members, chairs of NHS health boards and the Welsh Confederation. In addition the Deputy Minister met with RPB chairs and the WLGA Social Care, Health and Well-being Network of local government councillors ahead of the commencement of the white paper consultation.

To raise awareness of the publication of the consultation, the Deputy Minister for Social Services published a written cabinet statement[2] and provided an oral statement[3] to members of the Senedd. In addition, the Welsh Government Health and Social Care twitter account tweeted links to the consultation web page (throughout the consultation period) and an email link to the consultation was sent to

[2] Deputy Minister for Social Services' written statement to members of the Senedd of the White Paper
[3] Written record of the oral statement by the Deputy Minister for Health and Social Services: The Rebalancing Care and Support White Paper

stakeholders and national representative groups. To support accessibility to the consultation, an easy read version of the consultation document and response form were developed and a consultation video[4] was also uploaded onto the Welsh Governments YouTube channel, which was publicised using Twitter.

Two online public consultation events were held and attended by over 110 individuals from across the sector. In addition to the consultation events, the Welsh Government also met with representative bodies and groups, including:

- Commissioners in Wales; the Welsh Language Commissioner, Children's Commissioner for Wales, Older People's Commissioner for Wales and the Future Generation Commissioner for Wales' office
- Care Forum for Wales
- National Provider Forum
- Board of Community Health Councils (CHCs)
- NHS chief executives
- NHS directors of planning
- Chairs of the NHS health boards
- WCVA consultation response working groups
- Wales Vision Forum
- Learning Disabilities Special Interest group
- Regional Partnership Board (RPB) chairs, vice chairs and co-ordinators
- WLGA Social Care, Health and well-being Cabinet Members Network
- ADSSC consultation response working groups
- Ministerial Advisory Groups for Carers and the Foundational Economy
- National Commissioning Board consultation response group
- Heads of Adults social services
- Children's Commissioning Consortia Cymru (4Cs)
- National Collaborative Commissioning Unit (NCCB)

Next Steps

This summary of responses has been published on the Welsh Government's website.

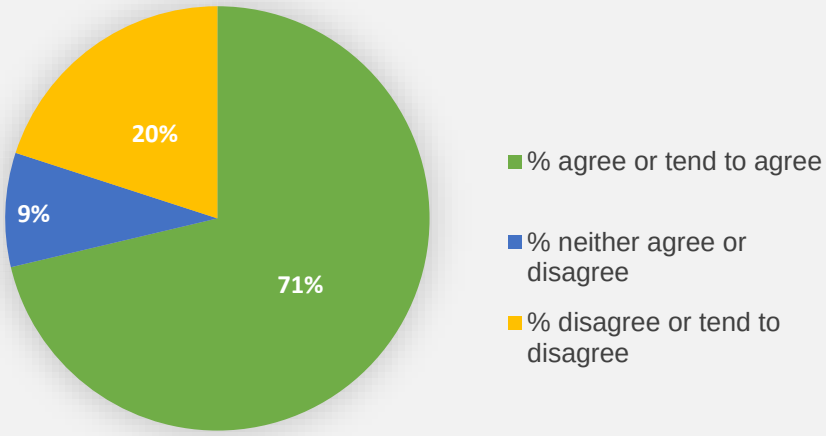
Further extensive engagement with the sector and with citizens will be critical to developing co-produced policy.

[4] Rebalancing care and support white paper consultation video

Question 1- Do you agree that complexity in the social care sector inhibits service improvement?

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 1 is shown is Figure 2.

Figure 2: Question 1- Do you agree that complexity in the social care sector inhibits service improvement?



Nearly three quarters of respondents agreed or tended to agree that complexity in the social care sector inhibits service improvement (71%). The majority of respondents felt that while complexity limits the pace of improvement, it is made up of many factors. Complexity was believed to be a result of many partnerships, different funding arrangements and charging regimes, different commissioning rates, inconsistent practice across Wales, inflexible procurement rules, significant duplication, lack of a shared vision or understanding of integration, disjointed services, separate inspection regimes for health and social care and the sustainability of the social care workforce. Not all reasons were cited as inhibiting factors for service improvement, however the majority of respondents who raised these factors noted that they created a more challenging environment for improvement.

Less than a quarter of responses tended to disagree or disagreed with the question. Responses noted that it is not always easy to avoid complexity in the social care sector. Many cited that complexity is inevitable in a system of many interconnected and different parts and is often a result of significant variation of diverse needs across different communities in Wales. Public sector responses noted that the current system is designed so that decisions can be made as close to people as possible and felt that integrated working at a more local level can deliver service improvement. This became more apparent from those responses that focussed on the impact of demographic profiles and geographical considerations e.g. rural compared tourban communities, levels of deprivation and other socio economic factors.

From a citizen's perspective, the third sector and individual responses often noted that the health and social care system is very difficult to navigate for individuals and families. One response stated overly complex services run a very clear risk that the people who need care and support the most may be the least likely to be able to access the care and support they need. People reported a lack of accessible information, poor communication between agencies and that they are unsure of what is available to them and their rights. A citizen response noted what is really important is for everyone to work better together and feel more united. Another respondent commented that simplifying the way the social care sector is managed would improve the uptake of existing services and is essential if people are to be empowered to reach their maximum potential. One third sector response suggested that greater powers need to be given to those receiving care and their carers, to ensure they are suitably prepared to have an active voice in the services they need and receive, and in providing feedback about the services they have received to improve delivery and quality of the service.

The complexity for children and young people's care and support were cited by many different respondents, and particularly the differences in complexity that exist in children's services compared to adults' services. It was noted that the key barrier to service improvement for children is likely to be due to inconsistent practice between local authorities and from a lack of integration between health and social care services, and that it is often difficult in accessing the right support for children looked after and their families. Specifically it was noted, despite efforts to improve, the difficulty in offering consistently appropriate accommodation with care to young people remains unacceptable and in need of urgent review and remedy.

Some respondents argued that the complexity is not due to the multiple parts but the lack of cohesion. A significant number of responses described a system with inherent complexity due to the requirement of organisations to work across local, regional and national boundaries – forming different relationships and partnerships with a range of purpose and underpinning values. Significant issues around transparency and communication between different services was highlighted, and inter-local authority communication was cited as limited. One respondent stated it could be argued that some of the complexity has come from a historic pattern of having to manage budgets at a local level and not looking at shared approaches across local authorities and partner health boards. Another stated the risk of partners acting in the best interests of their own organisation at the expense of other partners and that complexity is sometimes caused by competing agendas and responsibilities (for example NHS and local authority funding disputes).

Comments on the care and support market were more mixed. Some noted that the fragmented nature of the social care sector made up of numerous and predominantly small organisations means that it lacks resilience, is fragile and consequently results in time consuming contract management processes. A significant number of respondents highlighted potentially 22 different ways of commissioning multiple types of service and very large numbers of providers working in the same locality, making it difficult for them to collaborate with each other or with their local authority. It was noted that variation covers how bidding is undertaken, how fee rates are calculated, how performance is measured and whether commissioning is outcomes focused, or not. One public sector response noted it is difficult to form strategic

commissioning relationships that encourage innovation when there are so many providers in the market and much of the local authority and local health board commissioning resource is tied up with the contractual elements of the commissioning cycle.

In contrast, others did not agree that the numbers of providers were an indicator of complexity, in a system orientated towards social value they believed this may be seen as a feature of a community-based, innovative and responsive social care sector that responds to local need and positively benefits local people and places. The ability of all providers to provide social value was reinforced through a number of responses. One respondent noted that whilst oversupply of providers can lead to a lack of focus on quality and a race to the bottom in terms and conditions, undersupply and a small number of providers can lead to stifling of innovation and can minimise voice and control of people using services. Several responses felt that needs are best met by a range of organisations and market competition needs to remain to help stimulate service improvement.

A significant number of responses reflected on the current funding model for social care. Many respondents highlighted that that current funding arrangements impact on how care and support is commissioned and provided. Respondents believed that underfunding social care has led to a focus on driving down costs. The monopsony effect is described as a factor for inhibiting service improvement in itself, with little funding provided as an investment to support the sector to innovate and improve, or to invest in the workforce. In addition, procurement was described as limiting in that it prevents provider's being able to invest in the workforce when contracts are retendered frequently. The recruitment and retention of the social care workforce was often cited as a means of securing improvement in the sector, especially given the disparity with NHS terms and conditions. Responses highlighted that high turn-over of staff in some sectors, impacts on continuity of care and the ability to develop trusted relationships between people receiving care, and care givers.

Furthermore it was noted that complexity exists across the health and social care landscape due to social care being a means tested service, unlike NHS care which is largely free at the point of delivery. Social care services include those paid for and commissioned by the public sector, third sector or the individual and their families and carers. Some responses raised the complexities faced by self-funders and the significant variation in charges they face across Wales. Some responses from the third sector highlighted the complexities of their funding arrangements, through a variety of funding streams.

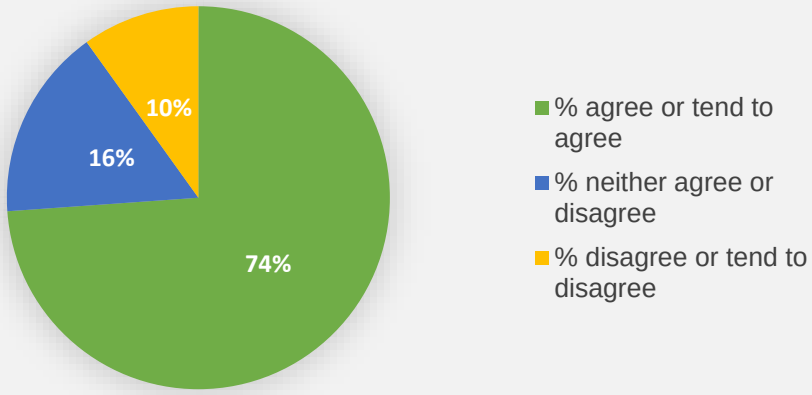
Respondents provided some recommendations for how complexity could be reduced through learning from others, sharing best practice, increasing consistency, reducing waste and removing duplication in the system. One respondent wrote the lack of coordination between different areas in Wales inhibits service improvement, as there is no standardisation to allow for shared learning. Specific examples of waste were cited as duplication and reinvention of procurement processes, commissioning services which are not flexible in responding to changing needs, including prevention and reduction of dependency and running a system which disincentives collaboration. In addition, many felt that these things could be mitigated through a mutual understanding of outcomes, quality and standards. One respondent noted the

opportunity for Care Inspectorate Wales (CIW) and Health Inspectorate Wales (HIW) in this supporting this understanding and increasing accountability and transparency across health and social care. A clear narrative between services of how all services impact on people, a shared vision for integration and shared measurement frameworks to monitor and assess improvement were stated as essential for driving improvement. Sharing data proved to be a common thread through all recommended proposals for increasing transparency and reducing complexity in the sector.

Question 2- Do you agree that commissioning practices are disproportionately focussed on procurement?

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 2 is shown is Figure 3.

Figure 3: Question 2- Do you agree that commissioning practices are disproportionately focussed on procurement?



Nearly three quarters of respondents agreed or tended to agree that commissioning practices are disproportionately focussed on procurement (74%) compared with other elements of the commissioning cycle. Procurement practices were described as often seeming to be an end in themselves, rather than a means to outcomes. It was felt there is too much emphasis on contract agreements, including unit prices and micromanagement of service delivery. It was also noted that commissioning capacity is a limited resource, compared with procurement functions. One respondent noted that a strong relationship between commissioning and procurement functions facilitates the identification of effective procurement solutions that support service quality, market sufficiency and development, and commissioner provider relationships.

Less than a quarter of responses tended to disagree or disagreed with the question. Those that disagreed highlighted the importance of procurement in ensuring robustness of contractual arrangements. The process of procurement was often described as making decisions on services based on a number of factors, including citizens voice, choice, the responding organisations policies and procedures and price.

From a citizens perspective, responses noted that current procurement practice inhibits choice for those being cared for as the process is used to reduce costs rather than focusing on outcomes and the needs of people or the quality of the service. Respondents agreed that current procurement processes seems inconsistent with an outcome and social value-based approach to delivering services and the principles of the Social Services and Well-being (Wales) Act 2014.

The resource available to the sector was a continuous theme throughout responses by all sectors. Respondents reinforced that limited budgets provided on a short-term basis inhibited the ability for the sector to improve, thus providing a challenge around long term planning and driving practice to focus on procurement as a means to drive down price through competitive tendering. An independent sector response stated that current procurement focus results transaction-based services that do not support securing outcomes for the individual. One public sector umbrella response called for further investment into the social care sector in Wales to help ensure that the vision set out by the White Paper, to rebalance the care and support market by moving away from price and towards quality, social value managing the market, and focussing on outcomes could be achieved.

The differing procurement practices for services for children and adults was raised by a number of respondents. One response noted that in relation to commissioning of children's placements, there is little opportunity for focus on quality of care and outcomes achieved as a consequence of there being little choice of placements available and significant time pressure to secure any new placement. There is also the fear of needing to make 'unregulated' arrangements as a result of not having a 'regulated' placement available.

A significant number of public sector responses cited procurement legislation as driving and limiting practice. It was noted that interpretations of procurement rules by legal teams have the potential to cause conflict between practitioners who want local innovation at speed and more cautious officials who require strict adherence to legitimate contract procedure rules and standards based on the advice they recieved. A few respondents noted that due to exit from the EU, Wales is no longer tied to EU legislation on procurement and called for a reform of procurement regulations to allow more freedom in issuing of social care contracts, learning from previous work of the National Commissioning Board.

In addition, many responses set the context of organisational corporate procurement approaches, which are often not tailored to social care, adding additional layers of complexity to the process. It was described that this complexity can limit innovation, disadvantage small providers, inhibit Social Enterprises to apply for larger contracts, make it difficult to work with providers on developing new services and to change services within the contract term. The way in which local authorities and local health boards are organised was also highlighted as affecting commissioning and procurement. The organisation of these functions within local authorities and LHBs was described differently throughout responses. Some suggested that in instances where procurement and commissioning functions are separated, procurement specialists may not have an in-depth understanding of social care, and commissioners may lack sufficient skills to challenge their procurement colleagues. While others stated that commissioning functions were subsumed into corporate procurement departments and therefore the understanding of the market has been lost with an increasing focus on reduced costs. Others set out that procurement officers and commissioning officers were the same people within the department. The effect was described similarly, with a view from some that the service contracts are designed for the convenience of the council's back-office functions, rather than the services which meets the needs of the local population.

A vast majority of responses highlighted that often there is variance in commissioning and procurement capabilities and in working practices and approaches between bordering authorities and between health and social care with many duplicating frameworks with slight differences. One response stated on occasions NHS and local authority organisations ‘speak a different language’ in regard to commissioning. Another added that marginally different questions are often asked in procurement tender exercises, resulting in excessive time re-writing for different local authorities. Furthermore frustration was expressed at working to different procurement systems, which were found to be very resource intensive.

Differences for commissioning at an individual level and a population level were drawn out in responses. The population level was defined a number of ways. One response described population as; cluster, locality and region, whilst another described strategic and operational levels. It was noted at a population level, commissioning needs to reflect the place-based model of care developed across health and social care, and the population needs assessments continue to meet the needs of the assessed populations. However the infancy of population needs assessments was raised, and therefore the impact of their limited ability to be used to support planning and commissioning. It is concluded that as a response, the concept of market shaping is missed, and local authorities and local health boards are looking to buy what is there. There is limited work on-going to develop the market, its sustainability, or to develop specialist placements locally.

Generally, there appeared to be a different understanding of the definition of commissioning and procurement. Some recognised procurement within the commissioning cycle and described procurement as a tool to commissioners while others saw these as mutually exclusive activities. One response called for a universal agreement of definitions and measures of quality and value and recommend an approach similar to that proposed in the National Clinical Framework – whereby a range of national quality statements and measures of outcomes are co-produced to set out the vision for specific social care services. Another said having a shared understanding of commissioning across organisational boundaries will be important especially if integrated commissioning is being considered.

Respondents provided further recommendations for how procurement practices could be better balanced within the commissioning cycle. Having standard approaches, contracts and practices would be helpful particularly where the same services are currently commissioned by different commissioners on different bases and the framework would add value by including such elements as baseline pay for social care workers, focus on integration of services at a local level. However, to be effective, it was recommended that procurement needs to be flexible to support effective person- supported care and delivery of more innovative models. In order to improve outcomes and drive up standards a commissioning framework is needed that delivers a clear and consistent specification and clear and measurable contracts defining outcomes that can be monitored with the partnerships. It should facilitate rather than stifle transformation.

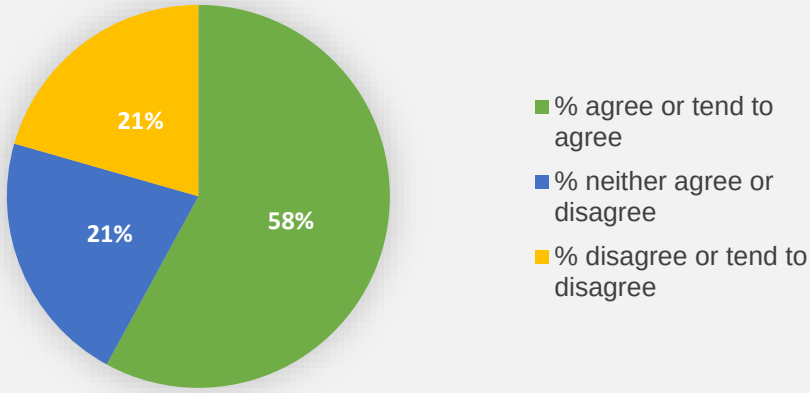
It was also considered there is an important opportunity to strengthen partnerships between commissioners, communities and providers to co-design imaginative local solutions in order to deliver the best outcomes for individuals whilst ensuring value

for money. Commissioners alone cannot deliver the scale and pace of change required to rebalance the provision of care and support, and communities and providers have knowledge, resources and expertise to bring to these shared challenges. This should include needs assessment, gap analysis, options appraisal, area plans, service design and evaluation. Improvement must be based on people's experiences of care as the current system does not represent commissioning against standards or quality but contracting for an affordable price.

Question 3- Do you agree that the ability of RPBs to deliver on their responsibilities is limited by their design and structure?

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 3 is shown is Figure 4.

Figure 4: Question 3- Do you agree that the ability of RPBs to deliver on their responsibilities is limited by their design and structure?



Over half of responses thought that RPBs were limited by their design and structure. The majority of these respondents were from the third and independent sector and from citizens.

Less than a quarter disagreed or tended to disagree with the question. These respondents felt the legislative powers to support integration and pooled budgets were already sufficient to enable RPBs to undertake their existing responsibilities. Some respondents thought that RPBs have developed considerably since they were originally set up and partnerships are continuing to grow and evolve over time, albeit at different rates. Many responses thought that partnerships are about trust and relationships, and therefore partners needed to work together to deliver the necessary change, and that changing structures would not achieve this.

One response noted the ability of the RPBs to deliver their responsibilities is limited more by their maturity and ambition than by inherent limitations in their structure and design. However one citizen representative of the RPB noted the proposed “hearts and minds” approach is unlikely to have the desired impact. Some third sector responses highlight a perceived lack of trust between partners.

From a citizen’s perspective, it was recognised that involvement of citizen and carer members on RPBs is an important element, which strengthens local voice. It was suggested that this needs to be strengthened to better enable co-production. One local authority noted that the way in which citizens and carers voice is secured varies across RPBs, and welcomed the development of more coherent governance arrangements. One RPB response believed that RPBs seem disconnected from

delivering outcomes for those who need care and support. An organisation that represents carers said that carer representatives feel their roles are tokenistic and that they are not valued. On this specific examples of limitations in co-producing decision with carers were cited, including issuing substantial papers with very little notice often and with the outcomes of agendas pre-determined and rubber-stamped. Some called for better developed regional citizen panels, where citizens were remunerated for their time. The board of Community Health Councils thought that any detailed proposals for creating RPBs on a stronger footing must ensure the new Citizens Voice Body is properly equipped and enabled to inform and influence the plans, priorities, activities and decisions of RPBs – in the same way that it is being set up to do with NHS bodies and local authorities.

The third sector reported frequently that they have found it difficult to engage with RPBs because of their structure, which varies across Wales. Some third sector representatives felt that decisions were made without any meaningful third sector input. Many stated that whilst it is valuable to have a third sector representative in these meetings, one representative assumes the sector is one entity with the same view. As a result, many third sector organisations are unable to share their expertise around the needs of vulnerable groups, which could help to influence and improve services. Some third sector responses noted they did not know who the third sector representative was, nor how to find out. There were calls to ensure diversity in how the sector's voice is represented. It was suggested that having an umbrella third sector organisation / overarching body in attendance should allow for greater opportunities for third sector organisations to feed into conversations.

It was also thought that RPBs are too big for effective decision making. The Gwent RPB was cited as an example of a board with up to 40 members, making effective engagement and dialogue extremely difficult. Some responses said that RPB membership includes local democratically elected Council members, and this ensures local voices and opinions are heard and that local accountability is at the core of the RPB. Conversely, another thought RPBs erode local democracy.

Some felt there can be a conflict of interest in expectations of RPBs, (e.g. in ability to share information that is commercially sensitive), when at the partnership table there are citizens, providers and other partners that may not have a 'need to know' the information. This may manifest in a perspective of other RPB members feeling that decision are made outside of the partnership.

The reporting requirements for Welsh Government grant funding was described as bureaucratic and burdensome on the partnership. Some thought the approach encourages a reactive 'funding-led' approach to investment and impeded the RPBs ability to invest in areas where there is greatest need for improvement at a local level. Similarly, statutory organisations felt RPBs were limited by short-term funding allocations, in some cases announced with very little advance notice. Audit Wales reported that they found little evidence of successful projects being mainstreamed and funded as part of public bodies' core service delivery. They also found that there is limited scrutiny of the decisions made by the RPBs by health boards and local authorities, with improvements needed in terms of organisations' awareness of how grant funds are being used.

In addition, it was highlighted that the driving of grant funding monies in RPBs is challenging when there is limited staff resource, and many RPB teams are funded through WG grants, by necessity. The National Commissioning Board noted that in other instances capacity is drawn from local health and government organisations, which restricts ability to undertake other activities. It was thought that there may be benefit both to partner agencies and the overall partnership to having additional specific regional capacity to drive partnership working. One third sector response added RPBs would benefit from a clearer description of their purpose with specified job roles and aligned job descriptions to facilitate effective functioning.

The power of RPBs to influence change in its partners was cited as a limiting factor. It was thought that competition for funding and resources is a major obstacle to joint working. Many responses noted that separate budgets and unbalanced power hinder progress. A third sector response thought most of the organisations that are involved in the RPB still have a limited commitment and retain a strong territorial loyalty to their parent bodies. One local authority response thought there are possible conflicts with existing legislation in relation to local authorities subsidising costs of services in another area. A local authority noted that with budget pressure a real challenge, collaborative and innovative commissioning can be limited by each organisation wanting to ensure they have control over local resources. There is less willingness to take such an approach to commissioning outside of the Welsh Government grant funding provided to RPBs.

In relation to grant funding, numerous examples were cited of members not feeling that they co-owned funding bids where that funding is held on behalf of the partnership by one of the relevant agencies, rather than being jointly held in the RPB. The National Commissioning Board noted that the requirement to hold and manage the distribution of funds creates power imbalance between partners.

One citizen response highlighted that partners may be reluctant to contribute to a pooled budget (they fear loss of control) until they can see the benefits. There is a need for partners to understand what they are putting in and what they are getting out and how all stakeholders benefit. It was suggested that trust can be built if the appropriate governance arrangements were in place to build confidence through transparency. However a third sector response stated the governance arrangements for the RPBs are totally opaque. An umbrella organisation that represents the voluntary sector believed participants struggle to understand the reporting and accountability line for RPBs, and thought RPBs need to be fully accountable, scrutinised and all meetings made open to the public. They believed this would ensure proper auditing, challenge and scrutiny. One local authority thought that Wales may benefit from more streamlined governance arrangements. If there was a 'once only' delegated decision-making agreement in place this would simplify and provide a more dynamic way of working.

Many noted that RPBs are limited by a lack of an agreed vision among partners. There were many calls for responsibilities in relation to A Heathier Wales, and the Social Services and Well-being (Wales) Act 2014 to be clarified; in relation to well-being, outcomes, co-production, collaboration and prevention. Directors of social services stated that there are a range of issues with the current model, not least the lack of clarity about the function of RPBs which have changed considerably since

their inception. In addition, clarity was sought on what RPBs are intended to be; strategic boards or operational boards. One respondent called for the purpose of integration both bottom up and top down to be clearly expressed. Examples were provided of both operational requirements (e.g. management of grant funding streams), and strategic requirements, (e.g. population needs assessment) placed on RPBs. In support of this, the response from the Care Inspectorate noted a lack of clarity on what RPBs do and a third sector organisation noted the remit of RPBs to be too extensive. Some offered a view about what the role and function of an RPB should be; a catalyst for sharing good/best practice; promoting transformation of service in line with A Healthier Wales but within the principles of the SSWBA 2014; identify exemplars and share these and providing challenge to services that are not transforming.

A third sector respondent suggested that the initial population needs assessment reports are not major priorities for most of the constituent bodies. Instead, they are more exercises in compliance than an engine for change and delivery. The Older People's Commissioner restated that her office also raised concerns in 2014 about the robustness and variability of Population Assessments, in particular in relation to advocacy services in Wales. Many RPB responses thought that, within the broad context of the duties set out under Part 9 of the Act and the objectives of A Healthier Wales, RPBs should be able to determine their own priorities, to address identified regional needs. Furthermore funding to the RPBs should be used in line with local decisions and RPBs priorities not pre-determined nationally.

A large RPB footprint was cited as a disadvantages by the majority of respondents from North Wales. One North Wales local authority noted making decisions and holding discussions at a regional level can be difficult at times, given the size of the region. A further example of this was cited; the Cwm Taf Morgannwg Health Board has recently split into 3 smaller Integrated Locality Groups (ILGs) in order to operate more effectively. They felt that despite regional service delivery on some very specific matters, experience shows that a focus on local work driven by the needs of residents will give better results to people.

Respondents provided further recommendations for how RPBs could be strengthened in response to the limitations through the consultation:

- Responses from primary care called for clarity about how any sub-regional working fits with neighbourhoods and clusters (place based care). RPB design and structure could still be improved further to integrate with other existing structures such as primary care clusters.
- One response noted an independent chair as a positive improvement to RPBs, as they could to look across sector and organisational divides impartially.
- One respondent proposed that RPBs should be set up to direct service provision and hold services to account. Another third sector organisation called for RPBs to hold statutory services and other care providers more accountable for the outcomes and quality of delivery that will be set out in the national framework. A local authority thought that legislation could make the RPB a more powerful body which could better hold the Health Boards to account.

- Clarity on the strategic and operational relationship between Public Service Boards (PSBs) and RPBs was sought. It was felt that greater integration with the PSBs would enable more effective strategic developments.
- Membership of RPBs need to be strengthened and diversified, specific examples of additional membership included NHS directors of nursing, professional bodies, WAST, umbrella third sector orgs, and unions.
- Many third sector organisations called for better transparency. They reported that websites are inaccessible, with limited information on how to contact the boards, and how to engage on any level. The RPBs also need to be accountable and transparent in the way that they make decisions and more needs to be done to ensure that meetings and the decision making process is transparent and properly scrutinised. In support of this, the board of Community Health Councils reported the information publicly available about the activities of RPBs is very limited and considered whether meetings should be open to the public. There was a view that if RPBs are to have a stronger role in the planning and commissioning of integrated health and care services then their visibility and accountability directly to the people and communities they serve needs to be significantly strengthened. As such, it will not be sufficient to create governance arrangements that demonstrate accountability through others. There needs to be clear requirements in place that ensure any strengthened RPB model with decision making powers operates openly and transparently. This includes meeting and accounting for its actions and decisions in public.
- A person responsible in the each local health board for ensuing partnership working happens and succeeds should be legislated for. This duty would match the duty for the Directors of Social Services. How all wider partners could be held responsible should also be considered, particularly if there is going to be any form of inspection of RPBs.
- Development of integrated health and social care evaluation and performance measures.
- A third sector organisation thought large leadership boards are not as effective as smaller executive groups at decision making. Establishing an executive group, informed by sub-groups on specialist areas of work, would be more efficient in terms of the generation of key intelligence and decision making. Specific examples included sub groups for children.
- One RPB reported they were limited by their relationship with the Welsh Government. The RPB called for a shift in focus from performance management of small schemes and projects, to one of seeking assurance on delivery of national policy at a regional level. In addition they thought RPBs should be held accountable for their medium term plans as clear, costed statements of intent.
- The National Commissioning Board described multiple different partnerships in play within the overarching RPB and recommend:

    - All partners should contribute assets to analysing population need, assessing range and level of existing services and gap analysis;
    - Local authorities and local health boards are responsible for the ‘make or buy’ decision and may then procure services;
    - Commissioners and providers work in partnership to deliver services;

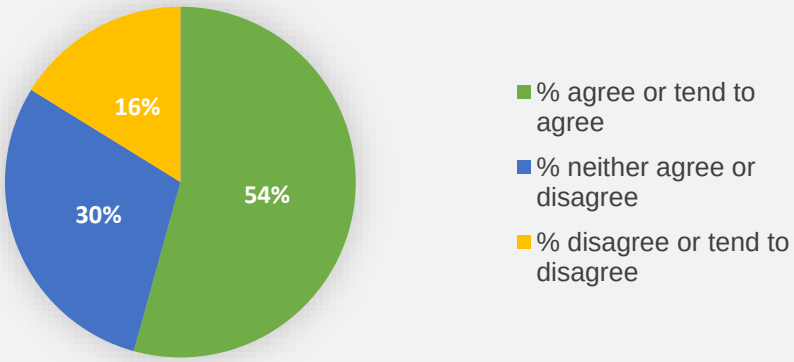
- Commissioners, citizens and carers agree outcomes to be achieved by services; and
- Providers, citizens and carers agree how to achieve the outcomes.

Question 4- Do you agree a national framework that includes fee methodologies and standardised commissioning practices will reduce complexity and enable a greater focus on service quality?

Question 4a- What parts of the commissioning cycle should be reflected in the national framework?

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 4 is shown is Figure 5.

Figure 5: Question 4- Do you agree a national framework that includes fee methodologies and standardised commissioning practices will reduce complexity and enable a greater focus on service quality?



Over half of responses agreed that a national framework that includes fee methodologies and standardised commissioning practices will reduce complexity and enable a greater focus on service quality (54%). Respondents that agreed or tended to agree with this question thought this approach would make the social care system more transparent. Providers (both in the independent and third sector) in particular welcomed the potential for the reduction of complexity and removal of duplication or waste, particularly when services are provided in more than one local authority area. Many advocated that all parts of the commissioning cycle should be included in a framework to drive consistency (analysing, planning doing/ securing services and reviewing), and improve integration between health and social care services. Furthermore population needs assessment, market position statements and area plans should be used to shape any national framework (at both the individual and population level).

Less than a quarter of responses tended to disagree or disagreed with the question. Many respondents sought further clarity on what would be included in a national framework and how it could be implemented, before determining the benefits. In general those who did not agree with this question believed a national framework would be inflexible, at the expense of local autonomy (as it is favourable for decisions to be made as close to people as possible). Conversely others thought

national frameworks have the danger of becoming so flexible to account for local or regional variances that they will cease to add value.

The definition of a national framework was sought by the majority of responses, including at what level it would be required to be used (individual or population level), whether it would be for different categories of care and include regulated and non-regulated services. Two different interpretations of framework were cited:

1. A national framework as a strategic supporting structure setting standards and principles for practice through tools and templates and promoting consistency in good practice, but not at the detriment of flexibility and local autonomy for decision making; and
2. A national procurement framework of providers that local authorities would be expected to draw down services from, such as those already in place for children and mental health.

It was noted that any national framework should align to the whole system values described in 'A Healthier Wales', focussed on co-ordinating health and social care services seamlessly, describing evidence based models of care at a national level, which is then implemented to meet local population needs. Respondents felt the there was much to learn from existing efforts to standardise commissioning practices in the social care sector and that the following should be included in a national framework, building on existing approaches:

- A shared set of outcomes, principles and values to facilitate the culture change set out in the Act;
- Quality standards for care and support (including setting out people's outcomes and rights), with a clear link to with the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017) and health and social care service inspections;
- Template contract documentation, including service specifications;
- A standardised fee methodology tools to assist in calculating the cost of different types of care;
- Template contract management and monitoring tools;
- Performance monitoring and reporting processes, including clear identification of the data required to inform commissioning (such as outcome measures);
- Evidence-based tools to facilitate sharing learning and supporting effective relationships between distinct parts of the system;
- Support around methodologies for trialling and testing novel approaches to delivering services through the likes of prototyping and iterative scaling of services;
- A single learning and development framework across planning, commissioning, procurement and contract management teams in integrated health and social care services; and
- Template section 33 agreements for integrated working and lead commissioning and pooled funds (Section 33 of the National Health Service (Wales) Act 2006).

In relation to citizens, an increased focus on commissioning by quality, outcomes, rights and well-being was welcomed. A greater emphasis on citizen voice was highlighted by many responses. Learning and reflection using people's experience of commissioned services was stated by many as vital to drive continuous improvement in the commissioning cycle. One respondent set out that the national framework should specify active engagement with people throughout the commissioning cycle: at the "analyse" stage, to identify needs and aspirations; at the "plan" stage, to influence service transformation, at the "secure services" stage, to improve quality and safety, and at the "review" stage, to ensure that the right outcomes and experiences are monitored, good practice identified and lessons learned. This view was backed by a number of other responses, another citing that all proposals need to have at their core a strong definition of co-productive commissioning. It was stated by many that any national framework must be built on an understanding that outcomes are best delivered by a partnership between social care workers and people themselves. Furthermore respondents highlighted the need for a commissioning model focussed more towards a social value-based model that secures well-being for people. Procurement processes must give higher ratings to organisations that promote cooperation, co-production and enabling approaches to service delivery and encourage stability, reciprocity and local capacity.

The differences between social care for adults and children was highlighted. For example, it was noted that children and young people do not have the ability to 'choose' their placements and any proposed changes need to ensure that children's circumstances are understood as distinctly different and so require their own approach. Within children services it has been highlighted that the sufficiency of placements is a complex and long-standing issue that will be a difficult barrier to overcome. Progress made by the 4Cs framework was suggested as a basis for further developing a national framework in relation to children, particularly to develop a quality evaluation process, to ensure guarantee over quality of placements and outcomes for children. One respondent suggested that it is critical that the work to date by the 4Cs on transparency of costs is used to further explore the variation in costs associated with all children's placements. The Children's Commissioner for Wales has called to move away from, and ultimately the end of, profit making in children's care services and noted there is a need to recognise this distinct difference in any discussions about commissioning and standardisation of fees, as vehicles to facilitate this important transition in children's care. Directors for Social Services in Wales thought the national framework would present an opportunity to explore capacity building of social value not-for-profit organisations for foster placements.

Fee methodologies gained a significant amount of interest and respondents commented in great detail about what could be included in these. The independent sector believed significant effort and energy is expended by both commissioners and providers in developing duplicate structures and fee assessment exercises with little or no tangible benefit. Learning from UK fee methodologies for domiciliary care and older person's care homes, the work of the National Commissioning Board and NHS Wales National Collaborative Commissioning Unit's costing methodologies were also highlighted as a basis for building upon. In addition, it was recommended that methodologies accommodate geographical and contextual differences. For instance, the cost of homecare in rural areas is higher than in urban areas because of

associated travel costs. Another example was cited as responding to the capacity and resourcing requirements of providers at different stages of their own business cycle. More specifically differing sizes of businesses have differing costs, larger businesses do not necessarily have economies of scale and equally smaller businesses do not always have lower overheads.

A significant number of responses linked the sustainability of the workforce to quality of services and requested that terms and conditions were agreed at a national level for the social care sector which commissioners would then require in commissioning arrangements e.g. Real Living Wage. Others believed that fee methodologies could provide opportunities for improved collective bargaining across Wales and a movement towards common terms and conditions across providers, ensuring differentials between care workers grades are not eroded. The work of Social Care Wales to support professionalisation of the social care workforce and their joint Workforce Strategy with Health Education Improvement Wales were cited as relevant in determining fee methodologies.

One respondent called for further clarity on whether fee setting methods are designed to arrive at bespoke rates per provider or standard rates per type of service or category of care. Respondents provided specific examples of matters that should be included in fee methodologies. Provider organisations cited wage related costs (including travel time, pensions, sick pay, national insurance contributions and so on) and non-wage related costs (eg. such as management, office costs, maintenance of building costs, registration costs, IT systems, ongoing training and up-skilling of staff). Conversely public sector responses noted that methodologies which assume commissioners are responsible for all care home costs may not be the most appropriate given a high proportion of beds are funded by private fee payers and commercial operators will often charge what the market will bear. It was also noted that annual increases in fees have often not kept pace with rising costs and therefore suggested that national annual inflationary uplift models are included in order to remove the duplication of effort across local authority areas or regions.

Many respondents noted that previous attempts at creating more consistency have often ended in divergence between those working on the same basis – most frequently due to different perceptions of affordability. Therefore the importance of local budget position as a factor in any methodology tools was cited numerous times by local authorities, in addition to a sustainable funding model agreed. Some local authority responses thought common fees models may be helpful in providing both transparency and a degree of consistency across Wales, however noted the ability for fees to be set locally must remain at a local level, ensuring both democratic legitimacy and appropriate reflection of local market conditions and costs which vary considerably even within regions.

The importance of local circumstances was highlighted, as was the continuing ability of organisations to define and secure provision in a way that meets their own priorities must be safeguarded. In such responses it was felt that a national framework needs to facilitate and support, rather than restrict this. It was suggested that the capacity for local/specialist variation is needed, and in those instances clear rationale for any variations should be presented. Whilst recognising potential benefits in terms of quality and consistency, it was stated that there is a need for a balance

between national frameworks and standardisation and local flexibility and determination, to ensure responsive care and support. Local authorities generally felt that if a national framework is developed then it needs to be agile and be able to keep up with innovative practice that happens at a local level to be effective. An umbrella organisation that represents the voluntary sector reinforced the need to recognise that communities are diverse and have their own characteristics, strengths and assets. Therefore, a national framework and regional standardisation and commonality needs to take this into account and have the flexibility to respond to local need and citizen-led action, to improve people's health and well-being.

There was some concern that smaller providers will be pushed out of the market by developing a national framework. A minority of responses raised risks of a national approach reducing the market to large, national suppliers who can meet the requirements of the Wales-wide approach, ultimately leading to higher costs and greater distance between care and community. To mitigate these risks, it was suggested that the national framework must include, promote, and prioritise local social enterprises, co-operatives, third sector and user-led services, highlighted in Section 16 of the Social Services and Well-being (Wales) Act 2014. In addition one local authority highlighted the importance of maintaining investment in local commissioning functions so that strong local relationships with local providers could be maintained.

There were a number of further recommendations set out. Co-production of the framework between services, people and Government was called for by the majority of responses. It was suggested that there should be some reflection and learning as to what has been achieved in responses to the pandemic, with a collective approach taken to agreeing common standards and what would be useful in a commissioning framework, and how this might add value to what already exists.

The identification, collection and use of data to drive commissioning, including outcomes based accountability, quality and performance was a common thread through a significant number of responses from all sectors. Firstly, responses called for the national framework to prescribe a unified approach to monitoring contract compliance and service evaluation, including clear identification of reporting data required. It was believed that this would remove duplication of providers sending often slightly different information to different commissioners. It was also suggested that this was expressed in line with evidencing compliance with relevant legislation, strategies, policies and actions plans. Secondly it was recommended by many that Wales wide market information was collected through a central repository of data. Thirdly, that population predictor demand modelling tools were developed nationally. To support this, it was highlighted that additional skills and capacity was required by commissioners for data collection, input, verification and analysis, turning information into intelligence that informs strategic decision making (including resource allocation) and planning. Development of a qualification framework for commissioners was suggested to ensure continuous learning for procurement teams, including understanding of how to use and interpret the national framework. Furthermore it was noted that work on data development should link with Social Care Wales around a wider data strategy for social care.

Moreover it was suggested that the creation of a national framework, if it included specific and national requirements in terms of providing services in Welsh, would be one way of ensuring that at least a baseline of expectations about the provision of services in Welsh exists nationally. This, in turn, could lead to an improvement in the quality of services that Welsh speakers receive. Of course, this would need to be complimented by regional and local procurement that reflected the more specific and local needs of those areas including the needs of Welsh speakers.

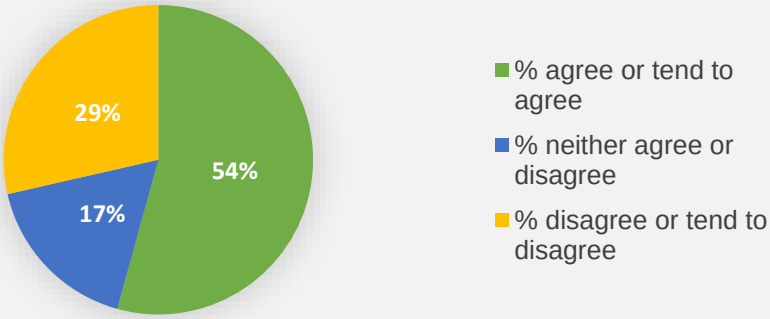
Question 5- Do you agree that all commissioned services provided or arranged through a care and support plan, or support plan for carers, should be based on the national framework?

Question 5a- Proposals include NHS provision of funded nursing care, but do not include continuing health care; do you agree with this?

Question 5b- Are there other services which should be included in the national framework?

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 5 is shown is Figure 6.

Figure 6: Question 5- Do you agree that all commissioned services provided or arranged through a care and support plan, or support plan for carers, should be based on the national framework?



Over half of respondents agreed or tended to agree that all commissioned services provided or arranged through a care and support plan, or support plan for carers, should be based on the national framework (54%). Many responses noted the benefits of this as encouraging and facilitating integration and joint commissioning. Many respondents reported that it was difficult to respond to this question without further detail of the purpose of the framework. Some respondents commented that not all services are commissioned, in addition there is also direct in-house local authority provision and alternative models such as direct payments. Therefore it was suggested that perhaps all services provided or arranged through a care and support plan, or support plan for carers, should be included.

Just over a quarter tended to disagree or disagreed with the question. Local authorities in particular thought some freedom to continue with local approaches to meet assessed need was required. Some described the need to develop bespoke

services in response to local need “off-framework”. Another response noted that a care and support plan must not be constrained by a pre-agreed set of available services. Those that described the need for bespoke arrangements and pre- agreed available services, were under the impression a framework would set out a list of service providers to procure from. One respondent noted that if a national framework sets out principles and broad guidance, then there will be greater applicability to all commissioned services, but if it seeks to be detailed and directive, then it may be more restrictive.

From a citizen’s perspective, the Third Sector in particular highlighted that all services should be based on an initial discussion with a person about ‘what matters to an individual’. This should always be the starting point and the nucleus from which to build a service for each individual. A national framework may then be the next step after that, ensuring that it is robust enough to be useful and flexible to adapt to the unique individual needs that each person using a service will have, and reflects the priorities and needs expressed collectively in care and support plans and support plans for carers.

Some respondents thought the scope of the framework should be based on a narrow set of care and support services in the first instance, which should then be broadened over time. Regulated services was suggested as a starting point. In relation to adults, domiciliary care, residential care and nursing care were cited. Another respondent suggested that all community services regulated by the Care Inspectorate should be included, as a minimum, regardless of which service contributes funding to that care. More specifically, where contributions to a care and support plan are made by health, these services should also fall in line with the framework

In relation to health services, responses questioned the extent to which health services appear in care and support plans, such as reablement services, mental health support (including therapeutic services for children) and physical health services (including physiotherapy), should also comply with a framework, given the requirement for regional population needs analysis, market stability assessments and area plans. A minority of respondents asked whether a framework should incorporate all primary, community health, social care services and public health.

More generally, examples were cited of services that respondents thought should be included in the framework, including supported living, advocacy services, services which focus on asset-based community approaches, adults with learning disabilities or autism whose behaviour results in their being placed in “assessment and treatment” units and hospitals, typically out of area or country and day services, and additional learning needs provision. It was stated that for children and young people the additional element of an interface with education must be included because education is a core pillar of children and young people’s future opportunities and outcomes.

The majority of responses agreed that NHS Funded Nursing Care (FNC) should be included and noted the interdependencies of FNC and NHS Continuing Health Care (CHC). The majority of responses thought that CHC should be included within a national framework, particularly as these services are commissioned from nursing

homes with residents who do not quality for CHC and often switch between FNC and CHC. It was reported that CHC seems to be a source of tension in funding and commissioning decisions because it can essentially determine whether social services or the NHS pays for the individual's care. Significant amount of organisational resources are consumed determining the lines between health and social care, which can be at the expense of an individual who is not then at the centre of decisions and whose care and support is often delayed. The Royal College of Nursing (RCN) Wales reported up to a third of their time is occupied by repeated assessment to distinguish between health and social care needs. A RPB response noted that free at the point of access health care has increased requests for CHC funding. In the absence of fully integrated health and social care budgets, some thought that keeping continuing health care separate could continue these current tensions and undermine efforts for closer partnership working. One respondent reflected on the considerable time and unnecessary bureaucracy which causes enormous division between local authorities and local health boards over their budgets. One respondent suggested that current CHC policy for adults is replaced by a policy that enhanced free nursing care (an enhanced FNC policy) and required a contribution (based on a financial assessment) for accommodation as they believed that no one should have free accommodation. They said this would make the system more equitable and significantly reduce waste in terms of time and resources. The respondent noted that some would argue that this could lead to charges for hospital accommodation but stated that hospitals are there to provide active treatment not accommodation. People living in nursing homes often require nursing intervention whether they qualify for CHC or not.

Children's and young person's continuing care arrangements was highlighted as one of the clearest examples of where successful pooled funding between health and social care would lead to improved results for children and their families. It was suggested that including CHC and Children's and young person's CHC on the same framework might ease challenges around transitioning from children's to adults continuing care.

Clarity about how a framework could operate beyond regulated services was called for. If the national framework is designed to take a system wide approach it is expected that prevention, equity of access, reducing health inequalities and socio-economic disadvantage will feature as key considerations. The importance of housing services for people who need care and support was cited, including extra care and supported housing. Conversely one local authority questioned whether alignment with housing services may best be achieved in other ways. Some noted that it is not clear how the development of commissioned care and support early intervention and prevention services and day services will fit within any national framework and how partners can be held accountable for preventative duties.

Further recommendations were stated. Respondents felt it will be important to address the issues that exist around joint and tripartite funding of care and support. Specifically in relation to NHS provision, many respondents called for developing a direct payments approach to CHC/ health funded care, in the interest of maximising people's voice, choice and control. However, respondents also recognised that including direct payments into a national framework would be challenging.

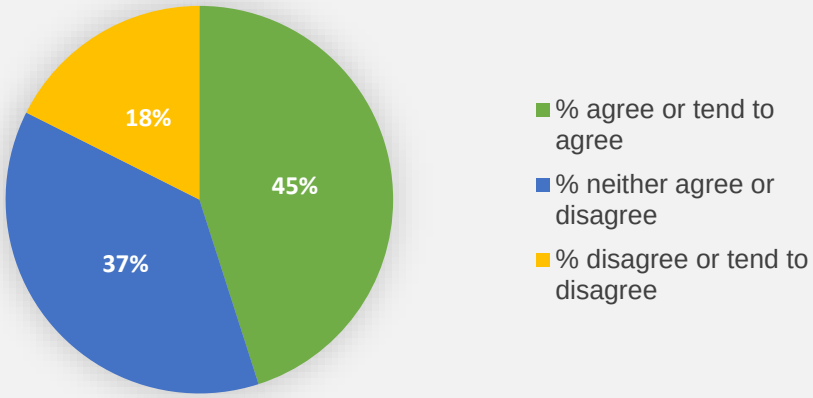
Finally, links with existing frameworks was highlighted, for example adults mental health and learning disability and 4Cs. Some respondents thought these frameworks should be merged into a national framework for care and support. Commissioning activities through the national fostering framework and national adoption service were also cited as examples of activities that merited consideration for a framework. Generally, it was suggested that further mapping of services needs to take place before to ensure a national framework has the right scope.

Question 6- Do you agree that the activities of some existing national groups should be consolidated through a national office?

Question 6a- If so, which ones?

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 6 is shown is Figure 7.

Figure 7: Question 6- Do you agree that the activities of some existing national groups should be consolidated through a national office?



Over a third of responses agreed or tended to agree that activities of some existing national groups should be consolidated through a national office (45%). Particularly in instances where consolidation leads to reduced duplication and greater effectiveness and efficiency. It was also suggested that consolidation would better support use of pooled resources. One local authority response noted that consolidation could be helpful if this leads to clear policy direction and genuine resources and support for commissioners to implement policy objectives. A health board added consolidation of existing bodies, groups and functions would engender greater consistency across different population groups and aspects of social care.

Many respondents reported that it was difficult to respond to this question without further detail of which existing national groups were being considered. In addition less than a quarter tended to disagree or disagreed with the question. These respondents thought the benefits that would stem from combining existing national groups by creating a national office were unclear and warned of adding additional layers of bureaucracy to the sector. One respondent raised concerns of diluting specialism through consolidating some remits.

The remit of a national office was considered, and generally respondents called for more detail on the purpose of the national office. A minority of responses called for a publicly funded and publicly delivered national care service for Wales and believed the establishment of a national office would be a step toward achieving this

overarching vision. The majority of respondents were clear that there must be added value to the creation of the office and it must not add more complexity to an already complex system. Some considered that a national office should be a co-ordinating body that develops and oversees implementation of a framework, more specifically that it oversees, scrutinises and holds accountable the procurement, delivery, quality assurance and outcomes for individuals and carers. The importance of a national body ensuring opportunities for reflection, learning and the exchange of best practice was raised a significant number of times. Respondents recommended that the national office is held accountable for driving improvement in care. In support of this, some believed that that an office should hold RPBs, local authorities and LHBs to account.

Others questioned whether the office would be an administrative/ secretariat support for existing bodies where these were not consolidated. A number of respondents thought a national office could strengthen national leadership to the sector. One health respondent thought an advisory body for the office should be set up, with membership set out in legislation.

A small number of responses thought the national office could bring together all national bodies responsible for social care including recruitment, workforce development, quality, improvement, regulatory standards, impact measurement, and public health. The majority of responses sought clarity on the relationship of the national office from other national bodies, those stated in responses were Social Care Wales (SCW), Care Inspectorate Wales, Health Inspectorate Wales, the Citizen's Voice Body, Public Health Wales, the Welsh Government (Department and leadership structure through national partnership board), the Welsh Local Government Association (WLGA), Data Cymru and the NHS Wales Executive. Others sought further details on relationships with existing commissioning groups such as National Commissioning Board (NCB), Children's Commissioning Consortium Cymru (4Cs), National Adoption Service for Wales, National Fostering Framework, NHS Wales National Collaborative Commissioning Unit (NCCU), and relevant provider and third sector forums, such as WCVA, Care Forum Wales & National Provider Forum.

Most responses from local government did not support any structural change or creation of additional bodies and called for formalising existing structures or establishing a national office in government rather than through a separate body. In addition Social Care Wales thought the creation of a new body outside of Government would generate confusion about roles and responsibilities with other organisations (such as Social Care Wales). Both Social Care Wales and the WLGA noted that if Welsh Government moved forward and established a national office could potentially be hosted within WLGA.

Others advised the national office needed to be independent of Welsh Government, in order to hold respective statutory partners to account and build relationships with the market. An organisation that represents providers believed that stronger executive powers and accountability for commissioners would be needed to produce better results in promoting changes in practice, such as ensuring compliance with the national framework. One health response stated a strong view that a national office should not be 'overlaid' on existing arrangements, noting the plethora of

groups that have some interest in this area and thus it may be a good time to consolidate and get alignment right.

A significant number of respondents questioned the relationship of a national office with SCW. Some thought SCW should be consolidated into a national office, some thought a national office was not needed in addition to the functions set out for SCW. Others considered, should they be separate in the future, that there is join-up between data, research, improvement, and workforce training and practice. In addition, it was cited that the office would need to work closely with the Association of Directors for Social Services in Wales, ADSS Cymru, as well as relevant local government, health and third sector bodies to ensure a whole system perspective. One respondent thought the national office would need to have an agreement in place with the Welsh Local Government Data Unit.

Further clarity was sought on the role of the national office in oversight of market stability. It was noted that at present, to varying degrees CIW, HEIW, Social Care Wales, RPBs and local authorities all have responsibilities around market stability and workforce planning (in relation to workforce planning, the commissioning of training places, and career pathways etc.). Local authority responses highlighted the strong understanding of market pressures, quality assurance issues and sustainability at a local level. Respondents were clear that this role needed to clearly link to the improvement work of Social Care Wales, Workforce Strategy for Health and Social Care and the role of the heath and care inspectorates.

The National Commissioning Board (NCB), hosted by the WLGA, was cited as a national group, which should be considered if establishing the national office. The NCB aims to exemplify the advantages of national collaboration, strengthening the relationships across service providers, commissioners and regulators for the benefits of people in need of care and support, offering an authoritative voice. Independent provider responses felt the NCB as currently constituted lacked power to enforce policy, resulting in a group that predominantly promotes best practice. Many responses stated that it would be critical that any 'consolidation' retains the high-level engagement that has been manifest in the board as currently constituted and the good levels of cross-sector participation and leadership. Members of the Board expressed a range of views in regards:

- The importance of the independence of the collective NCB from its' members' organisations.
- The potential risks of loss of independence, if the national office were a function within national government.
- Potential advantages for a national office, incorporating the National Commissioning Board being based within accountable organisation such as the Wales Local Government Association.
- Potential benefits of strengthening links with regulators (CIW and Social Care Wales) and shared objectives around market stability, developing data resource.
- That the NCB must not sit outside a national office function.

Some respondents thought that it would be beneficial to bring the Local Government led 4Cs together to ensure an all age national policy and operational commissioning

unit for children. However responses also noted a real concern that commissioning for children, young people and families could become lost in a larger all age national function. 4Cs take a role in strategic commissioning, policy development, good practice sharing and training. It may be difficult to consolidate such a breadth of activity. Therefore it was suggested that the specific focus on the needs of children through 4Cs should be retained in any future arrangements. Some responses described the breadth of work of the 4Cs and thought it was difficult to see how the breadth of this work could be consolidated into a national office. In addition, clarity was sought about how the National Adoption Service for Wales and the National Fostering Framework will operate within or alongside future arrangements.

A large number of responses highlighted the NHS NCCU, hosted by Cwm Taf Morgannwg University Local Health Board, and the corresponding Commissioning Care Assurance and Performance System (CCAPS). Responses thought that mental health and learning disability services should be considered as part of the framework and national office.

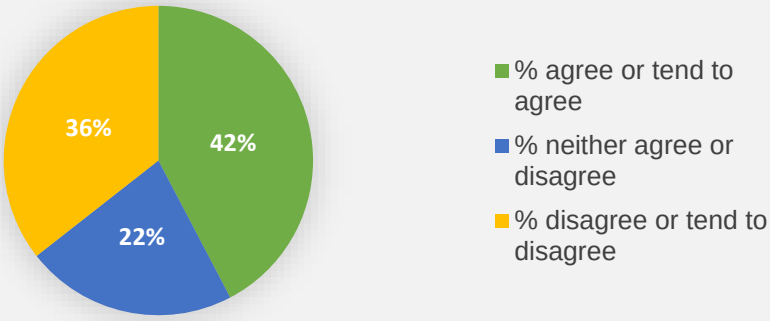
Further recommendations were provided for the establishment of a national office. In relation to the Welsh language, it was noted that if the national office is established at arm's length from the Government, it will have to be ensured from the outset that it complies with Welsh language standards in accordance with the Welsh Language (Wales) Measure 2011 and ensuring that Welsh language services improvements are a core responsibility of the national office. From a citizens perspective the organisation that represents the third sector stated that proposals must be clear about contribution to delivering against the principles of the SSWBA, especially in relation to equal opportunities and ensuring people have control over their lives.

Question 7- Do you agree that establishing RPBs as corporate legal entities capable of directly employing staff and holding budgets would strengthen their ability to fulfil their responsibilities?

Question 7a- Are there other functions that should be considered to further strengthen regional integration through RPBs?

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 7 is shown is Figure 8.

Figure 8: Question 7- Do you agree that establishing RPBs as corporate legal entities capable of directly employing staff and holding budgets would strengthen their ability to fulfil their responsibilities?



Over a third of responses agreed or tended to agree that establishing RPBs as corporate legal entities capable of directly employing staff and holding budgets would strengthen their ability to fulfil their responsibilities. The majority of these respondents were from the third and independent sector and from citizens. One citizen response thought establishing RPBs as corporate legal entities is a necessary step to ensure that competing pressures of local authority and local health board priorities do not undermine the ability to deliver on clear regional strategic priorities. However, often responses did not think strengthening RPBs in this way is the only action required and many responses cited challenges in RPBs implementing current functions effectively (in relation to transparency, accountability, co-production and measuring outcomes and impact). Therefore there were calls for a formal review of their structure, membership and how they are formed currently as part of any future reform.

Around a third disagreed or tended to disagree with the question. These respondents tended to be statutory organisations who believed that existing legislative provisions are largely sufficient to enable RPBs to discharge their functions. Many responses thought creating another legal entity would create unnecessary bureaucracy and complexity, particularly for commissioners. Some called for further evidence about how proposed changes would add capacity for improvement. Others highlighted the continued improvements made by RPBs, noted examples of successful integration

and instead called for strengthening existing arrangements (such as purpose, governance and accountability), rather than any structural change.

Generally more clarity was sought on the proposals, and respondents felt they needed more information to answer the consultation question. Questions from respondents included:

- Who would the RPB report to?
- Who would the RPB be accountable to? How would local authorities and local health boards hold the RPB to account for any delegated responsibilities?
- What will be the mechanism of deciding what services are delegated to the RPB to commission?
- How would complaints be handled?
- Would there be any change to the status of members of the RPB, for example, would the board members be subject to an additional level of accountability? Would non-paid individuals be remunerated?
- Would board members have voting mechanisms, including ensuring equity of voting rights to address the current power imbalance?
- Would proposals support more transparent decision making?
- Would proposals help strengthen meaningful co-production with citizens? Will the contribution of the third sector be adequately considered?

Many respondents reflected on the current purpose of RPBs. A body that represents the independent sector thought that RPBs play an important role in bringing stakeholders together to co-ordinate action and decision-making. However, many also thought they are a collection of parts rather than a regional leadership, and that creating a corporate legal entity able to employ staff and hold budgets may improve that. The directors for social services requested that Ministers are clear in legislation as to what the RPB is there to do, because the current model has allowed a degree of mission creep, with the RPB becoming a vehicle that has been used by Ministers to deliver objectives beyond what was originally envisaged. The Health Inspectorate Wales noted that they have undertaken a number of pieces of work exploring integrated service provision between health and social care. They reported through this work that often there are differences in structures, oversight arrangements and set up of services, which in turn led to barriers to good service provision being felt ‘on the ground’.

Restating and refreshing the role and purpose of RPBs was cited by numerous respondents. It was thought this would in itself provide an impetus for strengthened integration. Many called for shared understanding of what integration means, and a vision for integrated services and shared ownership of the principles of the SSWBA across social care and health. Some called for a recognition that integration and joint commissioning happens at many different levels, within clusters, localities, local authorities, sub-regions, regions and nationally. A health response called for clarity at the national level about how this can be balanced with regional approaches in a way that improves outcomes for people, recognising the variation of approach in different parts of Wales.

The Welsh Local Government Association and local authorities more generally thought it was wasn’t clear how the focus on ‘national’ and ‘regional’ will link in with

and support local communities and local delivery of integrated community-based arrangements. Clusters (also referred to as primary care clusters) were referenced numerous times; whilst the maturity of these were cited as differing across Wales, these were seen by the statutory sector as the arena for partnership between all partners at the local level, working in response to local needs. In relation analysing and planning for needs, it was suggested that there needs to be better alignment between analysis of needs at a regional level (through population needs assessments) and cluster or locality level. It was also recommended that RPB area plans respond to and align with cluster level plans, it was believed that this would substantially improve connectedness and local focus. An organisation that represents the NHS thought there was a danger that proposals to establish RPBs as legal entities move away from clusters and place-based models of care, integration with mental health services and community therapy/reablement services.

Most local authority responses questioned the relationship of an RPB with democratic structures. A RPB response noted the need to balance potential advantages of further regional working against the importance of local accountability during such conversations and welcomed the reassurance provided by the former Deputy Minister of clear continued commitment to local democratic accountability within the regional landscape. One local authority asked how the creation of RPBs as legal entities would interface effectively and efficiently with local government governance arrangements across a regional footprint. Another local authority sought clarity on an enhanced and appropriate governance framework that allows pre-decision scrutiny could continue to take place by elected members.

The National Commissioning Board noted that unless statutory bodies are both able and choose to delegate commissioning functions to such an entity, they retain sovereignty, therefore RPBs as legal entities are in danger of just adding a further layer of bureaucracy. A body that represents the independent sector believed establishing RPBs as legal entities will not necessarily change the fact that their constituent members may have divergent interests and their own, separate, legal obligations, accountability for public money, decision making processes, needs and strategic goals. If the responsibility for commissioning care and corresponding budgets remain primarily with the constituent members then it seems the tools or authority RPBs would have in influencing how care is commissioned or what care is commissioned are limited to building relationships, discussion, persuasion or analysis. A health board response thought that proposals needed further exploration and this could be supported by the development of a formula to create a support grant equivalent for RPBs. This will provide clarity on the resource envelope available and will inform strategic planning for each region. Critically, they thought this approach would avoid the uncertainty currently experienced.

In addition, a third sector response thought that to further support co-production and partnership working, the Welsh Government should look to integrate local authority budgets with those related to healthcare. It was thought that without further integration, competition between services will still exist and reduce sharing of information and best practice. A health board commented that pooled budgets have not been effective to date. The NHS Confederation thought the underlying issues regarding pooled resources may stem from the difficulty of numerous local authorities in a RPB area pooling funds that could potentially fund other services and

a lack of intent on a strategic level to deliver better outcomes. A response from the health sector thought that if RPBs are required to hold budgets then this is a tell-tale sign that partners of the RPB are unable or unwilling to work in such a manner. In response, they thought is that unwillingness or inability that should be fixed rather by changing organisational structure.

Some local authorities sought clarity on why it was thought pooled budgets at a regional level would deliver better outcomes for people in Wales. The Children's Commissioner for Wales specifically mentioned RPBs not 'holding' budgets as an entity in themselves as barrier to true joint working and thought that pooled funds should be required to be available regionally for emotional and mental health of children and young people, including jointly commissioned safe accommodation for children with complex needs. An umbrella organisation that represents the voluntary sector considered that specialist services needed to be commissioned regionally and nationally. Audit wales noted that legal entities may provide a stronger means to address the full spectrum of commissioning roles, including market shaping, which might help address the issues of trust that exist in the current system, as well as building better supply of specialist services. The Directors for Social Services questioned why CHC has not been an area of focus for regional working and explicitly excluded from pooled fund considerations, as they thought this area needed pooled budgets, better leadership and integration.

Another health board thought that the establishment of RPBs as corporate legal entities would enable external funding from Welsh Government to be allocated directly and would remove the need for the Health Board to be the 'banker' for funding. They thought this could simplify financial processes and reduce significantly the current administrative burdens on Health Boards. However this response noted that the challenges around local accountability would still remain.

In relation to capacity, a number of statutory organisations thought that agreement on shared posts between organisations is far simpler than the creation of additional staffing posts from a third entity or organisation. Local authorities questioned workforce capacity and raised concerns about depleting local authority capacity, skills and resources. Similarly, a local health board response raised concern that if RPBs directly employ staff, then this may result in a loss of key personnel and fragmentation of existing services. In response, one respondent asked whether commissioners could be seconded into an RPB and training packages available to strengthen experience and knowledge, thus building local capacity. Some thought that there is a real danger that partners may withdraw from their current levels of partnership if they perceive another body as being resourced to 'do the doing'. The Children's Commissioner for Wales thought direct employment of staff could improve accountability and accessibility of information about RPB activities, so that people can be empowered to know more about this work. A citizen believed having RPBs as a separate legal entity may help with the perception of independence and impartiality as currently the staff will be employed by one of the partner organisations and often have a primary base at one of the organisations. A body that represents the independent sector thought that the ability of an RPB to employ its own staff would support them to fulfil their legal responsibilities for strategic population needs analysis and market stability reporting by removing competing pressures. One third sector organisation called for statutory capacity for ensuring engagement, through an

engagement officer who can ensure the full involvement of all minority or marginalised groups.

Many third sector responses highlighted that the current configuration of RPBs does not provide enough opportunities for people to play an equal role and have a say in what matters to them. They thought that there must be better consultation and coproduction to ensure the needs of cohorts of people with particular health issues are driving the design of services. A body that represents carers called for carers to be remunerated for their time, regardless of the legal status of RPBs, in recognition of the time commitment and to facilitate meaningful carer engagement. It was believed that this would achieve co-production and better decision making.

Many third sector responses also raised challenges in engaging with RPBs, questioned the effectiveness of third sector representation on the boards and called for the membership of RPBs to be widened to ensure RPBs can fulfil their abilities, including umbrella third sector organisations, professional bodies, trade unions, and not-for-profit organisation representation. Some third sector responses thought that establishing RPBs as corporate legal entities would lead to potential improvement in third sector engagement opportunities. However one third sector response cautioned that if RPBs are set up as legal entities, whether this would be a realistic way of improving equity across Wales. Conversely the WLGA highlighted the implication of significant numbers around the table in increasing size of RPB agendas.

Specifically in relation to liability, it was suggested by a number of responses from all sectors that if RPBs were established as legal entities that the liabilities on individuals be considered and legal implications of transferring functions (particularly in relation to meeting needs and safeguarding). One respondent asked who would be subject to Judicial Review, legal action or Ombudsman action for anything that happens either to a person receiving a service or if there is a complaint by a provider for a service that has been commissioned, contracted and budget held by the RPB?

Some responses noted the additional costs to establish RPBs as corporate legal entities, for example dedicated HR, legal, finance and audit, TUPE of staff, procurement roles – which are often provided at cost price/in kind by partner organisations currently. Some responses described sharing back office functions currently. Responses questioned whether establishing RPBs as corporate legal entities would direct resources away from the front line.

Generally it was thought more frequent evaluations of services and monitoring of outcomes would be beneficial and that RPBs would require support to enable them to do this. A LHB response thought the development of a national integrated outcomes framework should set the outcomes RPBs will be required to deliver over the 5 year period in alignment with A Healthier Wales. Regional plans would set out how these will be achieved, focussing on local priorities. One response called for an investment in the National Data Resource (NDR), in particular establishing shared information systems and dashboards which provide longitudinal and trend data and intelligence for decision making.

One citizen thought it would be helpful if RPBs were free to hold LAs and LHBs to account. Another citizen thought holding RPBs accountable to a national body would

ensure greater consistency in their approach. Another thought by making the RPBs accountable to the national body, that real change may be seen, around leadership, behaviour, and flexibility when commissioning. Another thought giving RPBs a legal status will make it easier to move away from the institutional behaviour.
Third sector and citizens organisations thought RPBs, either in their current form or as corporate legal entities, need to be held to account better to the public.

Public health was suggested as an area that needs to be strengthened within RPBs. It was thought that stronger inclusion of public health functions at the RPB could support early intervention and prevention and the wider demand and capacity planning functions. Specifically this would allow closer working with GPs and linking into the enforcement role that councils have in areas such as food safety, environmental health and public protection. The Welsh Local Government Association thought it was an opportune time to examine the creation of a public health improvement role located within local government and called for the transfer of some of these functions from Public Health Wales, within the NHS, to LAs.

Many responses thought that Corporate Joint Committees (CJCs) were unable to subsume a RPB however they noted the potential extension of CJCs in relation to social care as a cause for concern. One local authority response thought setting up RPBs as corporate legal entities would be seen as creating CJCs through the back door. Another commented that the proposals felt like regionalism of social care. The Directors of Social Services in Wales called for a discussion about the decision not to establish a governance model based on the CJCs and called for a further understanding of the longer-term policy intention (linking to CJCs). The Welsh Local Government Association noted in looking at future arrangements for RPBs it needs to be acknowledged in the decision-making structure that the ultimate responsibility for use of public funds lies through the accountability structures of the major partners, local authorities and Local Health Boards and Trusts.

In relation to the timing of next steps, one third sector organisation questioned whether establishing RPBs as corporate legal entities is something that needs to be considered at this stage in the development of the national framework, or whether this is something that should be considered once the framework is in place. If the proposal in the white paper is taken forward, it was thought that RPBs should start ‘small’ before considering adding other functions. Some interpreted (and welcomed) the proposals as permissive, meaning that there would be no compulsion on RPBs to assume the new status, at least initially. Directors of Social Services in Gwent thought the option for RPBs to incorporate as legal entities should be determined by partners in the region, to set up when they are ready to take this step (and if they wish to take that step).

It was also recommended that if RPBs are established as corporate legal entities, that the corresponding legislation ensures that RPBs are required to comply with Welsh language standards in accordance with the Welsh Language (Wales) Measure 2011, and are subject to the Public Sector Equality Duty (PSED) under the Equality Act 2010. In addition it was questioned whether RPBs would be designated as Welsh Public Record bodies and in scope of the Freedom of Information legislation. Alternatively, legislation could require that RPBs put formal arrangements

in place with a local authority archive service or specify a local archive service with responsibility in each case.

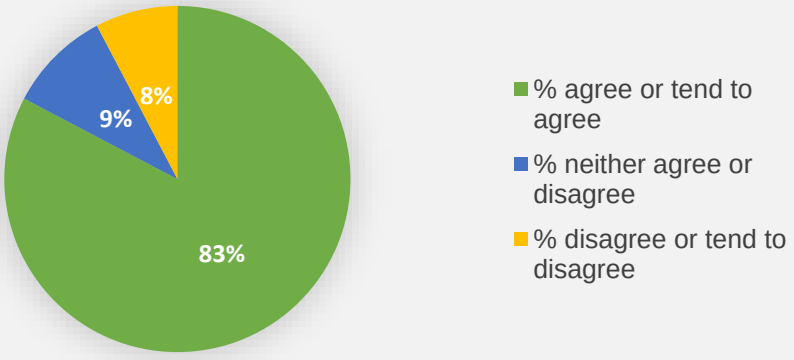
Furthermore, it was suggested that RPBs were made subject to joint inspection and review by CIW and HIW. In relation to jointly inspecting a strengthened RPB function to highlight issues and drive improvement, it was noted that there is a wide difference in the regulatory landscape between health and social care. Services may find they are required to respond differently to recommendations for action and improvement from CIW and HIW as a result of the different legal powers each organisation currently holds. An advisory group was established in 2019 to pilot an approach to inspection of RPBs. This work continues to progress. If this pilot of RPB inspections is successful, any permanent addition to HIW's inspection programme will need to be considered in terms of the resource implication that this will have.

Question 8- Do you agree that real-time population, outcome measures and market information should be used more frequently to analyse needs and service provision?

Question 8a- Within the 5 year cycle, how can this best be achieved?

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 8 is shown is Figure 9.

Figure 9: Question 8- Do you agree that real-time population, outcome measures and market information should be used more frequently to analyse needs and service provision?



More than three quarters of the responses received (83%) agreed or tended to agree that real-time population, outcome measures and market information measures should be used to analyse needs and service provision. Responses highlighted the importance of data in the planning process and thought concise and frequently updated information would be more responsive to changes in the population. The Directors of Social Services in Gwent noted that the aim of collecting and analysing information should not be to continuously plan, but to be responsive to demand changes and reflect learning from experience. Some pointed to learning from the pandemic in considering real time data in decision making.

A significantly lesser percentage of respondents (8%) disagreed or tending to disagree with the question. Those that disagreed tended to highlight the balance between the use of real-time data and the resource capacity needed and burden placed on services to deliver it. A citizen response cautioned that the collection and analysis of data is only useful if it is put to use and brings about change. Independent providers called for clarity about what data is to be used for and the extent it will influence decisions to be considered before collection.

Generally responses described an idea of collecting information once, and making it available in an accessible and transparent way for all to use. The role of the Welsh Government's Social Care Data Strategy and the data portal developed by Social Care Wales (which includes the former Daffodil system) to support planning and commissioning was raised by many respondents. The Care Inspectorate Wales

thought there is an opportunity to promote and formalise greater data sharing and transparency across providers, commissioners and regulators to deliver service improvement. Many called for a dataset to be co-produced by all partners. The National Commissioning Board welcomed the piloting of a shared workforce data system across providers, regulators and commissioners. A health board response thought shared data should inform the NHS planning and IMTP process. A provider welcomed consistent approach to data collection, which is not burdensome for providers, and reduces duplication.

Specifically in relation to the market, the National Commissioning Board promoted greater data sharing and transparency across providers, commissioners and regulators, focussed on market stability and sustainability, quality and value aimed at delivering service improvement. Longitudinal trend data associated with the market would be helpful, especially market oversight / intelligence. The Children's Commissioner for Wales thought monitoring provision and regularly reviewing stability of that provision would be an indication of sufficiency of that provision. A third sector similarly thought access to shared data would play a crucial role in ensuring needs and service provision are matched appropriately. Similarly, another described that it is only through regular updated information that would enable the right services to be available in the right localities. The Royal College of Nursing commented that the market stability reports should be monitored more frequently than their proposed 5-year cycle, as the market can change rapidly, and a 5-year cycle would be insufficient in capturing this data. A local authority raised the matter of the need to drive service improvement within the whole system and questioned whether there is a risk that the national requirements was causing a cluttered environment to emerge with the need to have in place a Population Needs Assessment, Regional Commissioning Strategies, market stability reports and market position statements – all with elements of duplication within them.

Most responses form the statutory sector thought capacity for analysis of data and intelligence is critical and is an under resourced area currently, with a gap in skills and capacity to interpret the data. A number of RPBs commented that they lack the capacity to collect, analyse and interpret data to create meaningful business intelligence to inform strategic planning and operational decisions. A citizen felt that people tend to revert to information available which may not be appropriate, rather than identifying the essential information and establishing the systems to capture it and subject to analysis. A number of local authorities thought if expectation around frequency of collection and analysis were to be increased, there would be a resource gap. A health board thought the challenge is for local authorities and health boards to have the planning, information and commissioning capacity to use this data properly to create useful intelligence to inform planning and commissioning. Specifically in relation to third sector, a local authority thought access to statistical analysis is essential as many providers do not have access to such analysis capabilities as in the statutory sector.

Some recommended that the same data be used to inform planning processes at a national, regional, local and cluster level in order to inform both short and long term planning and commissioning. A small number of responses from across the sectors thought there should be a central team for processing and analysing information, who then distributes key trends and learning points to local teams to integrate into

local knowledge from other sources. All of this could then be used to inform better local decision making. Other responses thought there is a balance here between what needs to happen and be coordinated at the regional level and what can only be collected and acted upon at the local level, in response to local needs.

With regard to outcomes, there were differing opinions around whether outcomes can be defined appropriately at a national level other than being population outcome measures as individual outcomes are bespoke based on ‘what matters’ within a place based approach at local level. Outcomes were described as being experienced by people and data needing to be extracted from people, their care plans and frontline workers. A response from the academic sector thought reliable and valid person-centred outcome tools should be developed which would help in service evaluations. Having a consistent set of outcome measures would aid comparisons across services. The third sector thought it is important there is not a sole focus on quantitative data and statistics, as the lived experiences of people are crucial to provide detail on people’s needs and the success of a service. An umbrella organisation that represents the voluntary sector thought if this was considered at a regional level, then RPBs could develop new skills and improved relationships with the public, so as to obtain the necessary data, particularly for the most disadvantaged, and those with protected characteristics. Engagement, co-production and transparency with communities was highlighted as a necessity within the transformation of services and quality improvement of services. In addition, a health board noted a practical challenge in not have a nationally agreed outcomes framework for health and social care, with a set of common measures.

A number of responses commented on frequency of data collection and reporting, generally it was thought long term planning through a five year cycle is not agile enough to respond to changing trends or unforeseen events. However, respondents noted the importance of long term planning to set direction an vision, alongside shorter term review, which was generally thought appropriate to be annually, as opposed to ‘real-time’ (other suggested reporting timeframes included a ‘live market system’, daily, weekly, monthly, quarterly and six monthly). A housing association thought population and market information needs to be as live as possible, and would need to be refreshed regularly to ensure changes to population are noted as they happen as far as possible**.** One local authority believed data should be collected and analysed annually, but on a local and regional basis with partners and people to respond to demand changes and need locally. A health providers cited the NHS process of in-built short- and medium-term reviews within a long planning cycle as a good example to follow. RPB annual reports were cited as a mechanism for reflecting on changes in population needs and service provision using more frequent data, under longer term population needs assessments and market stability reports. A body that represents independent providers called for the data infrastructure to automatically (but securely) gather data from systems without labour-intensive data entry, if it decided that it is needed ‘real-time’.

Question 10- What do you consider are the costs, and cost savings, of the proposals to introduce a national office and establish RPBs as corporate entities?

Question 10a- Are there any particular or additional costs associated with the proposals you wish to raise?

Many responses noted that there was not sufficient detail provided on the proposed national office nor around making the Regional Partnership Boards legal entities to be able to comment appropriately on these questions. Information relating to staffing, roles, and governance structure would be needed to understand any implications relating to costs or cost savings. Furthermore there were calls for analysis of the additional value of such entities in regards cost and benefit to citizens, and it was cited that the goal of legislative change should be to provide sustainable, equitable and better quality care and services.

In addition many individuals who responded commented that good social care will not happen without investment and also integration of services does not automatically lead to cost savings and many pointed out that there is a cost to bureaucracy. Cost savings will only be achieved when there is a higher investment and focus on preventative services so that individuals are not requiring high cost commissioned services. In addition, one local health board thought that the national framework is likely to have limited impact unless the underlying funding issues are addressed.

Setting up and maintaining a legal entity was felt to have significant set up costs and then ongoing costs. Many noted that there would be a need to fund new posts within the entity e.g. Section 151 officer, audit, HR, legal. There could also be TUPE implications for staff already in roles supporting regional and/or RPB activity. There would also need to be appropriate insurances to guard against liabilities particularly in relation to commissioned services and any legal implications that may arise if something goes wrong or if the entity was subject to legal challenge or judicial review.

Trade Unions provided comments on ensuring that there are equitable terms across each team created, ensuring that an unintended consequence would be a two-tier workforce however, in the longer term, it was felt that there could be some cost savings. Some local authorities raised the issue of ensuring that structures put in place have the ability to conduct its business through the medium of Welsh due to importance of this within health and social care service delivery. There is concern that regionalising or nationalising would dilute this to a detrimental level.

It was felt by some public sector organisations and RPBs that there may be some activity that, if undertaken nationally on a ‘once for Wales’ basis, would save officer time. The types of activity related to ‘big ticket’ items such as national minimum wage and terms and conditions for social care workers equitable to NHS workers.

Many concerns were raised about where the additional funding would come from and feared this would be taken away from front line social care delivery, which would

be a detrimental impact on the outcome that is sought within the case for change. One RPB thought that any cost saving is likely to come as an outcome of the transformation programmes which are underway within each region rather than from the solutions proposed within the White Paper. Even with an increased requirement of regional commissioning it was felt that costs of maintaining RPBs at their current status was going to incur additional costs and there is concern already emerging with key funding streams such as the Integrated Care Fund and Transformation grants being in their final year. It seems more logical to some that the additional funding that would be required for the national office and legal entity establishment would be better spent improving the quality of services through paying the National Minimum Wage to care workers. However, one anonymous response felt there was a need to increase the capacity of staff who have the expertise and skills in commissioning due to rising levels of need and the need to develop innovative services e.g. more use of technology and reablement services.

Some third sector organisations felt there was a need for a dedicated funding stream for their sector and thought a national office could be cost effective but cautioned around what was termed to be a Cardiff-centric view but recognised that having multiple locations for a national office would add to the costs and the costs may well out-weigh the benefits of setting up in the first place. Whilst setting up RPBs as legal entities makes sense it was not felt it would work when the accountability remains with the local authority for market sustainability and budgets and some local authorities also have their internal care provision. The role of the national office was raised as it seemed to duplicate the elements that are already the responsibility of Care Inspectorate Wales or Social Care Wales such as workforce, market stability, research and best practice. A third sector organisation also raised the cost to the sector representatives that sit on the RPBs, their time costs money to their employing organisation. Also one third sector organisation felt that RPBs should be funded to improve and increase their ability to co-produce and to undertake partnership planning rather than funding to create them as a legal entity.

An umbrella organisation that represents the voluntary sector commented that most of its participants had concern that bureaucratic tiers sucking money away from front line service delivery with bigger teams drawing on monies that could be better used in preventative work and social care provision in the community. It was however felt that having funding to improve co-production was far more important than structural changes. The Directors of Social Services in Wales also caution that they would not be supportive of diverting funding from creating integrated teams or service delivery to create the national office nor creating RPBs as legal entities.

Some RPBs have already pooled core funding to support the RPB meetings and infrastructure. There is concern that there would be a perverse incentive created whereby the pooling arrangements would need to be dissolved, and recognition that making the RPBs legal entities would require more funding than that currently being pooled.

Welsh language questions

Question 11- We would like to know your views on the effects that a national framework for commissioning social care with regionally organised services, delivered locally would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favorably than English. What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

Question 12- Please also explain how you believe the proposed policy to develop a national framework for commissioning social care with regionally organised services, delivered locally could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language

The importance of the Welsh language in providing care and support services was described as a right and a matter of need and necessity, not a choice. The Welsh Language Commissioner believed that not providing services in Welsh to those who wish to receive them in Welsh means that there is a lack of quality of care that that individual receives, which could have an adverse effect on the individual. Many stated that a bilingual person is better able to communicate their concerns in the language of their choice. This was stated as crucial across all age groups. The Older People's Commissioner for Wales noted that language choice is often important for the frailest and most vulnerable, particularly in areas with high levels of first language Welsh speakers. A small number of responses added to this and noted that when a bilingual person has a diagnosis of dementia or a stroke, it is often proficiency in a second language that is lost first, which can result in lonely or socially isolated circumstances due to a linguistic barrier, if services are not available in someone's first language. Both the Older People's Commissioner for Wales and the Children's Commissioner for Wales highlighted the importance of people being able to receive services in the language of their choice, and not having to be sent far from home, or out of Wales.

Generally the majority of respondents felt that the sufficiency of Welsh language provision across Wales needs strengthening to meet needs. In relation to impact, some respondents felt the impact of proposals on the Welsh language needed further consideration as they develop, particularly the impact on opportunities for people to use the Welsh language and on not treating the Welsh language less favourably than the English language. The Welsh Language Commissioner specifically commented that further consideration needed to be made before drafting any legislation. The Commissioner also emphasised the need to consider the implementation of the Social Services and Well-being (Wales) Act 2014 in relation to

Welsh language services and that improving those services is a crucial consideration in shaping social services policies and legislation, including those outlined in the white paper.

It was noted by many that public bodies already have statutory duties placed upon them to plan and provide services through the medium of Welsh, outlined in the Welsh Language Standards[5] under the Welsh Language (Wales) Measure 2011, and that these duties would continue to apply, regardless of any changes proposed. On that basis the majority of respondents that commented on language thought there would be no impact (positive or negative) on Welsh language provision. The Welsh Local Government Association agreed that the duty to ensure that there are opportunities for people to use Welsh and on treating the Welsh language no less favourably than English already exist. They outlined that what is more important is ensuring that citizens are aware of this right and are enabled and empowered to receive any services in their chosen language.

Most local authorities thought any changes proposed would strengthen compliance with the Welsh Governments strategic framework for Welsh language services in health and social care, More Than Just Words. However one local authority called for a guarantee that future development of policy is in line with More Than Just Words Framework and the Welsh language standards. The Welsh Local Government Association noted that the key principles of the More Than Just Words Framework had been embedded into the Social Services and Well-being (Wales) Act, including that all people and organisations involved in the delivery of social care must have regard to the right of people to communicate in Welsh. They thought that regardless of whether there is a national framework or not, it is essential that services that are being arranged take this into consideration. They also thought a national framework would provide an opportunity to embed the More Than Just Words Framework further.

The role of commissioning in enhancing Welsh language services was cited by a significant number of responses. An individual noted that improved commissioning practice can only enhance the experience of Welsh language citizens. It was recommended that national framework should reference legislation that protects the rights of Welsh speakers. It was thought by some, that the inclusion of Welsh language into the national framework could have the potential to influence the strengthening of Welsh language services by providing clear baseline standards and expectations for the provision of Welsh language provision and by ensuring that providers are fully aware of the Welsh language standards. The Welsh Language Commissioner specifically thought that in turn could potentially lead to an improvement in the quality of services that Welsh speakers receive.

One local authority believed that language must be an integral part of any commissioned care service. To strengthen this, another thought the national framework should outline a criteria relating to the provision of Welsh medium services; and this should be scored in the competition to provide that service. The Directors of Social Services in Gwent thought any national framework approach should lead to greater consistency in language and terminology, which should allow

[5] Welsh Language Standards

for consistency in use of the Welsh language and consistency in translation, as needed.

The Care Inspectorate Wales thought the national framework must include consideration of meeting Welsh language needs and all commissioning strategies, plans and market stability reports should identify deficits and gaps with plans to address these. The Children's Commissioner for Wales noted the availability of services and information through the Welsh language is a right for all children and should be expressly considered when looking at placement sufficiency and commissioning arrangements.

A third sector response welcomed the national office playing a role in highlighting good practice in applying Welsh language standards. The Welsh Language Commissioner encouraged the inclusion of Welsh language social care and service improvement as a central element of the national office's activities by mainstreaming that into the organisation's objectives and by ensuring that it is a core responsibility of the national office advisory board. It was also suggested that if a national office is established at arm's length from the Government, that it complies with Welsh language standards in accordance with the Welsh Language (Wales) Measure 2011 from the outset.

Links to the workforce were explicitly made and the challenge to attract, recruit and retain staff with Welsh language skills. One local authority noted that the sector requires access to appropriate levels of staff who have Welsh language skills and it is important that existing staff are retained and others with an interest are encouraged to develop skills. Another local authority noted the challenges in recruiting staff Welsh language staff in the context of many lacking the confidence to call themselves as fluent Welsh speakers. It was suggested that to address the language skills gap, funded opportunities to learn or improve language skills could be provided, such as a collaboration with the National Centre for Learning Welsh to provide a sabbatical course (such as that for teachers) and/or deliver short courses to raise confidence in using verbal Welsh in the delivery of services. One local authority felt that having a central service resource of welsh speaking professionals would be beneficial. Conversely another thought that any national framework must emphasise the need to promote the use of the Welsh language while at the same time provide space for the application of local solutions that will have the greatest impact in a given area.

A third sector response recommended that partnership working and sharing of Welsh language resources could mean that areas that have greater resources available in Welsh can share with those areas that do not have a breadth of resources but still need to meet the needs of Welsh speakers in their area. An umbrella organisation for the independent sector thought providers' ability to recruit and retain Welsh language speakers would most likely be improved if fee rates offered to providers allowed for more competitive pay and terms and conditions. The Directors for Social Services in Wales perceived a potential challenge to be around the linking of language need to the question of fee setting, as methodologies don't take into account the cost of providing a bilingual service and the cost of improving Welsh language skills of the workforce. The Welsh Language Commissioner raised concerns that there is currently insufficient data on the workforce and the needs of

the population to be able to plan Welsh language services and the workforce adequately. The Commissioner believed there is a need to identify what new data should be collected and to establish a method of using it throughout Wales in order to plan Welsh language services and the workforce.

In relation to regional proposals, the Welsh Language Commissioner raised concerns that Welsh speakers are not, at present, adequately reflected by all RPBs. Furthermore the Commissioner thought there were shortcomings in the population needs assessments and in the accountability of the boards. It was recommended that if the Boards were established as statutory entities, they should be required to comply with Welsh language standards in accordance with the Welsh Language (Wales) Measure 2011. A small number of responses highlighted the need for RPBs, if not already, to be conducting its business in a bilingual manner.

A third sector organisation thought that consideration should be given to respond to the needs of people whose first languages may not be Welsh or English, and/or for those who require or prefer alternative methods of communication (such as easy read, braille, large print, or BSL). The importance of accessibility generally was raised by many respondents. It was felt that in addition to language of choice, ensuring and promoting the accessibility of documents ensures fairness and equality. And that addressing the wider communication needs of the population in the framework would enable and empower people with care needs to have more choice and to better communicate their needs.

Other proposals

Question 9- Do you consider that further change is needed to address the challenges highlighted in the case for change?

Question 9a- what should these be?

Question 13- Any other comment(s) you wish to make about the proposal to develop new legislation?

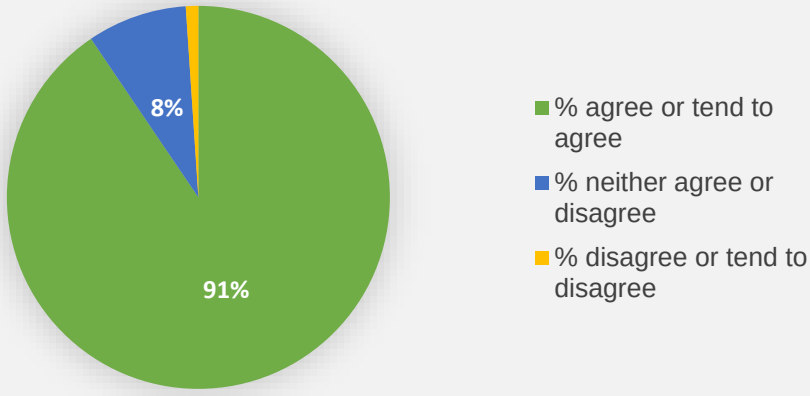
Throughout the responses, a number of core themes were identified, listed below:

- Outcomes
- Co-production
- Advocacy
- Social value
- Culture and leadership
- Welsh language
- Funding
- Direct payments
- Procurement legislation
- Workforce

Views against these themes are embedded within the summary of all consultation responses for each question and addressed specifically in relation to the responses received specifically to questions 9 and 13 below.

The percentage of respondents who agreed, tended to agree, neither agreed or disagreed, tended to disagree or disagreed with question 9 is shown is Figure 10.

Figure 10: Question 9- Do you consider that further change is needed to address the challenges highlighted in the case for change?



- Outcomes

Generally, it was felt that whilst the white paper set out a clear intention to improve the quality of services, it focussed on systems and processes and therefore there were calls for the impact of the proposed system changes on people and the outcomes that matter to them to be described. Moreover it was agreed that the principles of the 2014 Act, such as voice and control, need to be reflected when developing new arrangements or supporting legislation so that they are at the heart of any new approach. A third sector response believed that it is vital that provisions are made to ensure that the quality of care does not differ between areas of Wales.

In relation to a national framework, responses thought a framework represented an opportunity to ensure care and support is provided based on outcomes and what matters to people. One response stated that commissioning should focus on the needs of the citizen, offering a seamless service between health and social care. The opportunity for commissioners to ensure that upholding human rights as a core element of high-quality social care was cited by many. One response recommended that Welsh Government should set equality outcomes in the national framework for commissioning to address inequalities faced by groups receiving social care. The Human Rights Commission thought any new commissioning practices are underpinned by strong compliance with the PSED in that they aim to eliminate discrimination, advance equality of opportunity and seek to foster good relations between groups with protected characteristics.

The importance of measuring and monitoring outcomes and experiences was stated by many. In particular, responses agreed that greater accountability on those commissioning the services, and those providing care services, should be integral to driving improvements in performance and quality of the care services. A response from a body that represents the third sector thought it is important that the new system is able to measure meaningful outcomes that are both quantitative and qualitative. This will require ongoing data collection and analysis, which will be particularly crucial within a five-year cycle, as it will allow for prompt action in response to the changing needs of communities. Question 8 is a good starting point

for this conversation following the end of the consultation period as the data will play a pivotal role in ensuring that needs and services are proportionally matched.

Local authorities in particular noted that the starting point for discussions should be around improving the quality of care and achieving outcomes for individual, based on the 'what matters to them' conversation. They highlighted the need to preserve a social care system which is led, commissioned and delivered close to local communities, enabling decisions taken about funding to be made with local people meaning that what is commissioned is what really matters to people. It should build on the strength of local authorities in their role in place and community, addressing the needs of individuals and families, building resilience and focusing on wellbeing. A third sector respondent thought a national framework should be made operational at a local, regional and national level. In support RPB response noted that citizens needs are complex, so a range of regional, locality and cluster based services that enable a real choice not a perceived one are required.

A third sector representative organisation thought it was important to emphasis community-based, local, and place-based social care services, in order to move away from the current monopoly in play and create circumstances where organisations know their communities and are given a level playing field to provide bespoke, tailored services through social value commissioning processes.

- Social value

Generally, the proposal to rebalance the sector towards social value was welcomed. A third sector organisation thought that the care and support sector in Wales could potentially deliver wider social value beyond the delivery of commissioned services: helping to build and support communities by offering sustainable employment in local communities, offering training and career progression to help build communities of care in both rural and urban areas across Wales.

Relationships were cited as being very important to develop commissioning based on social value. A shift towards a more co-operative and community-led approach, where the public sector takes an active role in building and nurturing communities in order to create an environment of collaboration and resilience was called for. Member-led organisations launched with an independent model have the potential to be a radical solution to these challenges and should be explored further. It was also noted that any proposed legislation should complement the Social Services and Well-being (Wales) Act 2014, and promote alternatives models of care and support.

It was accepted that price has been a dominant factor to the detriment in commissioning care and support services to the detriment of providing what matters to people and has made it difficult to grow and invest in Section 16 type organisations delivering alternative models of service delivery. While proposals may be helpful it may not necessarily mean there will be a greater investment in alternative delivery models and this element of work may need specific additional resources. Some responses highlighted the factors that can undermine and inhibit promoting social value. It was agreed that Wales needs a sustainable social care workforce supported by a Real Living Wage that offers job security and recognition in order to build sustainable services that can focus on quality and consistency of care.

Responses that focused on rebalancing the social care market towards council run in-house provision or at least towards 'not for profit', highlighted funding as key to success, particularly in relation to parity between social care staff with health service staff. The independent sector recognised that a multiplicity of providers of different types e.g. large chains and "mom and pop" businesses as recognised in the Government's Economic Strategy Prosperity for All and third sector providers all bring something to the mixed ecology of services which can and should be used to improve services for citizens. The ability of all types of services to provide social value should not be underestimated.

It was suggested that Social Value Forums could become the body that is able to experiment and make recommendations as to what kinds of social value models can deliver sustainable care and support services in local communities. Respondents said it is crucial that Social Value Forums interact with the RPBs and a national office, but the question is whether this will result in too many structural layers being constructed, which will ultimately lead to too much bureaucracy.

- Co-production

Co-production was a theme highlighted throughout many responses in relation to the development of individual citizen care and support plans, citizen involvement in the design and delivery of services in their area and in relation to partnership working with the third sector. There were calls for how proposals will enable meaningful co-production to be clearly described and for an on-going meaningful conversation with people about the proposals, so that they are developed with people who use or may be impacted by changes in the way services are designed, planned or delivered.

Responses were clear that there is a need for robust mechanisms in place for citizens to have a clear say as to how they are supported to enable people to take more responsibility for their own health and well-being. One third sector response believed that services need to be more citizen and user directed where co-production of provision is the heart of the assessment and delivery process.

In addition, responses highlighted the need for people to be involved in the design of care and support services from the outset. Responses described a power imbalance between people who are receiving services and those delivering or providing access to care and support services. A response from a third sector organisation noted that whilst many organisations in Wales now consult service users when designing or delivering services, doing so often seems to be an afterthought or a 'box to tick' rather than an integral and valid part of the process. It was recommended that RPBs and a national office should be clearly remitted to promote coproduction, to surface examples of effective practice, and to challenge practices which continue to exclude the voice of the citizen. It should exemplify coproduction in its own activities, by ensuring that the experiences and perspectives of users and carers are a major part of its learning processes.

Generally, there were concerns about the effectiveness of partnership working with the third sector, who describe themselves as having the local knowledge and connections needed to advocate on behalf of their respective population. Responses called for any change to ensure equality and parity amongst all the partner/stakeholders. A response from a body that represents older people's

organisations said that some members have noted that when approaching commissioners with ideas for services that could be developed in partnership they have been reluctant to engage. Even when approaching commissioners with fully developed services which could be scaled up, they have misinterpreted these approaches as requests for finance alone and reject them, rather than engage constructively and improve services for the people who need them. It was recommended that steps are taken to ensure better co-production with third sector.

- Culture and leadership

"The challenge in creating a more sustainable future for social care relies on changing prevailing the culture. The challenges faced by the health and social care community are often of such scale that no one single agency, can manage them alone. A wide range of agencies, and organisations statutory, non-statutory, local, regional and national have capacities to respond to various aspects of these complex challenges. However, lack of coherence among diverse national, regional and local Stakeholders has resulted in, the potential for working at cross-purposes, competition for funding, duplication of effort and sub-optimal economies of scale. Lack of coherence is one of the factors often cited as contributing to limited success and lack of sustainability. Experience suggests that promising national initiatives have had limited success because of failure to achieve strong national vision and/or ownership at local and regional levels. Regions have endeavoured to develop explicit approaches aimed at fostering greater coherence, the extent to which this has been accomplished, to date, is unclear. However, if there is to be the sustainable improvement, envisaged by the Social Services &Wellbeing (Wales) Act the model of planning and coordination must be better integrated into a single country-wide approach. A major cultural change is needed, and this requires the same courage and creativity that has been so ably demonstrated by individuals, communities, organisations and government working together since the beginning of the pandemic. Partnership must involve the public, 3rd and private sectors, primary care, local people, community groups and be led by our local elected representatives. It should be built on trust, have shared values, shared priorities and shared outcomes."

In support of this statement from one respondent, many responses thought that strong leadership and vision will be needed to transform the system into one that truly collaborates in the interests of the citizens and communities. A response from a housing association considered that active consideration should be given to the associated cultural changes needed to realise the vision set out in the white paper. A third sector response highlighted a crucial element of change to be through encouraging continuous learning and experimentation. A local authority response thought that trusting relationships between providers and commissioners together with strong personal relationships can lead to innovation and the creation of new service models to meet local needs. It was recommended that for the proposals to be successful, these relationships would need to be fostered and re-established as part of the RPBs. A citizen added that specifications / contracts make a contribution but far more important is that all managers and their staff among both commissioners and providers understand how they can provide care and support which is personalised to the individual and helps them to achieve the outcomes important to them.

- Workforce

Respondents were universally agreed that workforce is fundamental to delivering high quality care services and supporting vulnerable people across the whole social care sector. The pandemic has had a devastating impact on many, if not all, working in social care. Directors of Social Services in Wales stated "*The importance of the workforce across children's and adult social care, including wellbeing, professional development, effective recruitment and retention cannot be overstated. We are very proud of our staff who selflessly and relentlessly rose to the challenge of supporting the nation's vulnerable people during the pandemic.*"

The urgent need for greater parity between NHS healthcare workers and social care workers across the board was widely acknowledged by the majority of respondents. Regarding pay it was noted that NHS pay is determined by a single pay body which is not the case for social care, and respondents thought this needs to change. There was much evidence and research highlighted indicating that low pay in the sector leads to high staff turnover and difficulty recruiting. Generally, it was thought there is the need to achieve a workforce who are truly valued, have parity of esteem with NHS workers and are appropriately rewarded for the invaluable work they do and have a pathway to career progression within a professionalised care sector.

The majority of respondents called for and supported the implementation of the Real Living Wage with some drawing links between commissioning and workforce sustainability. There is a request for more detail on proposals to develop a national minimum rate for different types of care, to be built on an agreed methodology that reflects the true cost of providing that care, with staff wages at Real Living Wage (RLW) as a minimum, and funding included for central costs of running services, as well as appropriate training and support for staff.

Some noted that whilst the introduction of the social care worker card and the two additional recognition payments for the social care staff have been broadly welcomed, it was expressed that they are no substitute for appropriate pay and conditions and a pathway to progress within a professionalised care sector. The comments also strongly supported a case for developing a learning, evidence-enriched culture in social care. There is a wish to see the support for the workforce extended from a focus on pay and conditions (which are seen by some as a bare minimum) to include a focus on training, learning and career development opportunities. This would amount to a significant change in the way that the social care workforce is viewed, valued, and remunerated.

Respondents noted the skills and experience required to undertake support work are complex, with key decision making about levels of medication users require, for example, being made by individual carers on a day-to-day basis. A union response in particular stressed that the importance of the Wales Union Learning Fund cannot be underestimated in terms of the impact that has been had in training and developing the social care work force and as such this Fund needs to be maintained to ensure the objective of a highly skilled professional workforce is to be achieved. This respondent also believes a public awareness campaign should be undertaken to deepen the understanding of the care sector and the roles of care workers, believing this would help in repositioning care work to allow it to be fully understood and therefore fully appreciated and rewarded. They also thought that the kudos that prevails in health services is seen <u>not</u> to exist in social care. Social workers are

typically perceived as occupying lower status roles than health counterparts. This inequality gets in the way of collaboration and integration efforts. As stressed by two prominent statutory services, there is continued importance and challenges of the Black, Asian and Minority Ethnic social care workforce, particularly during the pandemic.

The White Paper is seen as an opportunity to address the pressing workforce issues across health and social care by many. Currently the NHS benefits from staff who are recruited into entry level social care posts, often at minimum wage. They receive basic training and gain some experience that enables them to move on to work in the NHS, where there is a career structure and better terms and conditions. Workforce planning should be a joint responsibility, properly resourced, so that this transition of staff between the two sectors can be managed, with opportunities such as apprenticeships and joint training factored in.

- Direct Payments

The Older People's Commissioner for Wales commented that in its description of the complexity of the social care market, the White Paper recognises that people commissioning care and support for themselves directly are part of the picture. They also noted the difficulties people encounter within the direct payments scheme.

As explained, direct payments can be used for an individual to arrange for home care, for example through a Personal Assistant (PAs), instead of the traditional approach via a local authority. There is variation across Wales in how these are used and take up has been low. It would seem that direct payments to older people are often used as a last resort, especially in rural areas, when domiciliary care providers are unable or unwilling to provide care. As such, the new commissioning arrangements must include provisions to help more older people, including carers and people living with dementia, benefit from the flexibility of direct payments without being overwhelmed with unfamiliar and onerous responsibilities on top of the issues with which they are already struggling.

Noting that direct payments are predominantly used for the employment of Personal Assistants, there was a call from independent providers for these individuals to be registered with Social Care Wales. In requesting this, though, the comment was also made that as Personal Assistants need to be able to work safely, need to be identifiable, and need to be supported to develop their skills, there should not be a double standard with regards the regulatory treatment of Personal Assistants compared to other care workers.

A third sector organisation encouraged the take-up of direct payments and explore the potential of Individual Service Funds to give people the ability to design their own packages of care & support to deliver outcomes that matter to them.

Some also called for direct payments to be used as contribution towards Continuing Health Care (CHC).

- Welsh Language

Three authorities commented on Welsh Language, with one stating that the availability of Welsh speaking support is largely hindered by the recruitment and

retention issues across the sector. Another local authority highlighted that the Welsh Government's "More than Just Words" strategic framework to offer services in Welsh to patients in care settings as an integral part of the care provided to them. Whilst welcoming the emphasis on the Welsh language, the final authority thought reflections regarding the well-being needs of the diverse residents of Wales, as detailed in the protected characteristics of the Equalities Act needs to be defined.

A Welsh language organisation and the Welsh Language Commissioner agreed that a full review of the impact of the proposals on the Welsh language should be undertaken. They noted that real change is needed to address this clear gap in provision. Another third sector organisation stated that a sustainable Welsh-speaking workforce will also be critical to meet the care and support needs of people whose first language is Welsh, particularly where people experience communication challenges. They noted the importance in ensuring that people with Welsh language skills are attracted into, and retained within, the social care workforce. They suggested a needs mapping, with appropriate reward and progression opportunities to ensure Welsh speakers see a career in social care and remain within their communities to provide these services.

Finally, a community health association representative referred to the comments made in Care Inspectorate Wales reports that some residents are not receiving the dignity of care they deserve, especially with regard to receiving care in their first language. When/wherever possible the rota should include a Welsh speaker for each shift. They believed that Welsh language services are easier to provide in the patient's own home than in a care home as significant numbers of domiciliary care workers are drawn from those living in the local community, whereas there is a dependency in the residential care sector on the use of a smaller set of care staff.

- Funding

The predominant comment expressed by the varied respondents is that sustainable funding is the most pressing challenge to be addressed. The current funding model is noted as inadequate with calls for a real need to invest both time and resources to bring coherence to the long-term funding question and to design a system which is able to effectively meet any new and additional demands which social care will face in the future. A warning was expressed that without a sustainable and adequate solution to the funding crisis in social care the proposals risk creating additional financial and administrative burdens on the sector without creating the funding to address this. Respondents saw a real risk that the proposals will disrupt the market without addressing the most urgent issue. Although recognising Welsh Government's commitment to continue to lobby the UK Government to deliver on its pledge of addressing the challenges of social care, it was stated that if these efforts are not successful, many of the consultation paper's objectives will not be achievable.

Some thought it was premature to bring forward a White Paper for consultation without the findings of the Inter-Ministerial Group on Paying for Social Care. A respondent reported they were unclear as to why the White Paper proposes to consider funding through a separate Paying for Care Group, particularly given the central importance of the financial framework and the fragility of the social care sector. The need to create an affordable and sustainable approach to the funding of

social care is recognised, but some thought that considering funding as a separate strand of work risks losing the opportunity to consider a model that not only focuses on quality and value but is also robust, affordable and sustainable.

Respondents believed that without designated funding to support the proposal it is likely to miss its goals - a collaborative and creative approach to the funding of social care, including options around utilisation of tax receipts and strategic financial planning that outlasts local and national governmental terms of office. This view was shared by a citizen response, who believed the focus on the care and support market should instead be shifted towards public provision. In support of this, they thought that a national conversation is needed about securing proper funding for social care through general taxation.

The provision of grant funding was currently seen as short-term by a number of respondents, often being confirmed only during that financial year. The “prescriptive” nature of some programmes such as Flying Start was also brought into question particularly by local authorities who would wish greater autonomy over how they use their grant programmes with the aim of implementing (or developing them if they do not already exist) evidence-based solutions. Short term funding was viewed as restrictive in terms of being able to embed services in communities and to those they seek to support. Single year funding is particularly prohibitive and can be almost as harmful to vulnerable people as having no service at all. There was a stated impact upon the ability to find funding for preventative schemes, also infiltrating into problems in relation to staffing. Short-term funding contracts lead to high staff turnover and takes the focus away from quality of service for users and onto recruitment.

This issue of staffing was picked up further by a third sector respondent who comments that the current system does not provide sufficient funding for commissioners to pay fees that would allow providers to pay the level of wages that reflect the value and outcomes of the work that care workforce are delivering to citizens. They saw the system being driven by cost, rather than the value and outcomes that social care delivers for individuals and communities.

A local authority stated it is critical to address the issues in the care home market for a publicly funded capital investment programme (similar to the priority given to the schools modernisation programme) which will enable local authorities and partners to invest strategically. They saw the transformation required for the older person’s care home sector as being significantly beyond what is reasonably feasible through current capital resources.

Finally the point was made that fundamental changes, which fully recognise and reflect a position where health and social care are equal partners in the aspiration of delivering one seamless health and social care system for Wales, are needed. In saying that, it was recognised that funding alone will not be enough to address all existing challenges, and that a progressive vision for social care - which clearly articulates the vital role social care plays in society - must be committed to. A more preventative, asset-based, accessible, co-produced and joined-up system of care and support.

- Procurement reform

A single authority commented on this aspect and highlighted a number of issues, namely that; one of the biggest barriers is the complexity of local contract procurement rules and inconsistencies around how Public Contract Regulations (PCR) 2015 are interpreted locally. A union response though expressed concern about how UK legislation on procurement will interact with legislation at Wales-level. They believed that UK legislation on procurement reform could effectively override the intentions of this White Paper, particularly as early indications are that Welsh Government intends to follow the Westminster blueprint for procurement.

- Advocacy

The Older People's Commissioner for Wales believed the commissioning of Independent Advocacy services to help ensure that people are informed of and have access to their rights is fundamental in the promotion of human rights and must also be a consideration for commissioners. This must include ensuring that people know what rights they have and how to exercise them. This view is shared by a prominent statutory service who see access to independent advocacy as being crucial to enabling people being central to decisions about their own care and support and that they have voice and control.

A third sector organisation stated that unless services such as self-advocacy, specialist advocacy provision for people with learning disabilities and asset-based community approaches are invested in, legislation such as the Well-being of Future Generations (Wales) Act and the Social Services and Well-being (Wales) Act is destined not to deliver in the spirit the act was intended. They state self-advocacy to be the best form of advocacy and the ultimate preventative service for people with learning disabilities. Without it, they warn that the Social Services and Well-being (Wales) Act will have the unintended consequence of taking the voice of people with learning disabilities back to pre 'All Wales Mental Handicap Strategy' of 1983.

Annex A- Rebalancing Care and Support White Paper – Consultation Respondents

This Annex does not include those respondents that requested to remain anonymous.

1. Statutory Services

Archives & Records Association
Ceredigion County Council
Audiology Standing Scientific Advisory Group
Merthyr Tydfil CBC
North Wales Regional Partnership Board
Powys County Council
Care Inspectorate Wales
Gwynedd Council
Citizen Representatives in Powys RPB
Children's Commissioner for Wales
Health Education and Improvement Wales
National Commissioning Board
Newport City Council
Pembrokeshire County Council and West Wales Care Partnership
Denbighshire County Council
Betsi Cadwaladr UHB
Cwm Taf Morgannwg UHB
Conwy CBC
Vale of Glamorgan Council
Neath Port Talbot CVS
Rhondda Cynon Taf CBC
Welsh Ambulance Services NHS Trust
Socialist Healthcare Response Cymru
National Adoption Service for Wales
Isle of Anglesey CC
Gwent RPB
Gwent Directors of Social Services
Cardiff & Vale UHB
Royal College of Nursing Wales
Older Peoples Commissioner for Wales
South East Wales CVC
Blaenau Gwent CBC
Royal College of Occupational Therapists
Swansea Council
Carmarthenshire County Council
Public Service Ombudsman for Wales
Cwm Taf Morgannwg RPB
Audit Wales
Hywel Dda UHB
Ceredigion PSB
Caerphilly CBC

Flintshire County Council
Newport City Council
Practice Solutions
Association of Directors Social Services Cymru
Human Rights Commission
West Wales RPB
Strategic Programme for Primary Care
South West & Mid Wales RSP
Cardiff & Vale RPB
Social Care Wales
Wrexham CBC
Welsh NHS Confederation
Community Health Council in Wales
Aneurin Bevan UHB
West Glamorgan Regional Partnership
Welsh Local Government Association (WLGA)
WLGA Social Care & Well-being Cabinet Members
Bridgend CBC
Welsh Language Commissioner
Healthcare Inspectorate Wales
Swansea Bay UHB
Cardiff Council Social Services
Rhondda Cynnon Taf Childrens Services
The Children's Commissioning Consortium Cymru (4Cs)
Rural Health and Care Wales

2. Third Sector

Shine Cymru
Shared Lives Plus
North Wales Learning Disability Transformation Team
Shared Lives Plus
Glamorgan Voluntary Services
Age Connects Morgannwg
National Pensioners Convention Wales
Pensioners Forum Wales
Welsh Senate of Older People
Linc Cymru Housing Association
British Red Cross
All Wales Peoples First
Steddy Ltd
Community Housing Cymru
Pobl Group
Community Hospital Association
Cartrefi Cymru Co-opertaive
Mencap Cymru
Hafal
Welsh Council of the British Geriatrics Society
Hospice UK
Age Cymru

Alzheimers Society Cymru
Barnardos/Action for Children/NSPCC Cymru
Anheudda Cyf
WCVA
Wales Co-operative Centre
Rural Health & Care
Disability Wales
Credu
Care & Repair Cymru
Age Alliance Wales
ClwydAlyn
Hafod Housing
Powys Association of Voluntary Organisations
Multiple Sclerosis Society Cymru
Wales Vision Forum
Carers Wales
Conwy Connect
Cymorth Cymru
Calon Y Cymoedd
Welsh Womens Aid
Co-Op & Mutuals Wales
Pembrokeshire Association of Voluntary Services
National Deaf Childrens Society
Dyfodol I'r Iaith
Learning Disability Ministerial Advisory Group
Leonard Cheshire Cymru

3. Individuals/Independent Sector/Academic/ Trade Unions

Tony Sawyer
Sam Haywood
Penny Lloyd
John Morgan
Ruth Sharratt
Flynn & Eley Associates Ltd
Unite Union - North West Wales Retired Union Branch
Developing Evidence Enriched Practice (DEEP)
Professor Lorraine Morgan
WISERD
University of Birmingham
The Oaklands Residential Home
HC-One
MHC (UK) Ltd
UKHCA
UNISON Cymru Wales
BASW (CYMRU)
Care Forum Wales
National Provider Forum (Wales)
Domiciliary Care Manager
Awtistiaeth-DU (Cymru) CIC