



## **Royal Commission on Long term Care for the Elderly**

### **Continuing Care Conference Submission No 2:**

#### **Standards of Service**

##### **Introduction and Background**

The Continuing Care Conference (CCC) has a long-standing commitment to securing mandatory national standards for all long-term care provision. While we have a strong interest in regulatory issues, we recognise that regulation plays only one part in service delivery. This submission does not provide a comprehensive analysis of current trends or list of proposals but concentrates on a number of specific questions relating to standards of service.

CCC recognises that discussion of service standards cannot be divorced from fundamental questions of funding; the role and limits of regulation, and the position of the consumer. Such broad issues often contain unspoken questions that point to the need to balance conflicting, and equally legitimate, principles or objectives.

For instance, how do we recognise and acknowledge choice, and the principle of consumer involvement, whilst managing costs and coping with predictable budgets? How do we close the gap between the desire for higher standards and the availability of funding to deliver those standards? These are fundamental questions that the Royal Commission will have to consider.

The specific questions we address are as follows:

##### **What Standards?**

Q1 *Where is the line to be drawn between basic provision, adequate provision, and a truly first rate service?*

CCC recommends that national standards should be set at the level of ‘minimum’, or guaranteed, standards that provide adequate care. The criteria for accessing that care must be consistent and well understood. We discuss assessment of needs and eligibility criteria in more detail in a separate submission to the Royal Commission. While we would hope that ‘basic standards’ and ‘adequate provision’ were synonymous, achieving this objective will depend heavily on the solutions found to the central question of funding. We commend the work being undertaken by the Department of Health on benchmark standards. It is our view that it is important to ensure that there is no confusion between mandatory standards and best practice.

The Audit Commission / Social Services Inspectorate Joint Reviews of social service departments have highlighted several issues in the overall management of care provision. Key issues relate to strategic planning, the management of risk and how resources are allocated or prioritised. One danger (fallen into with often laudable intentions) is attempting to spread resources too thinly, thus resulting in low-level, poor quality care for many. National eligibility criteria are critical in this context.

CCC recognises that pockets of excellence do exist within care provision but the overall system of care provision is some way from being 'a truly first-rate service'. We believe that it is both desirable and possible to achieve excellence but it is not the role of baseline regulation or standard-setting to do. Within organisations, regulatory standards must be the 'floor' rather than the 'ceiling' to which management and staff work.

In 'macro' terms, many other interdependent factors contribute to excellence, including:

- how the national policy framework is set;
- whether there is sufficient and well-directed funding;
- how market mechanisms and management practices operate;
- the continuing involvement of, and pressure by, consumers, and perhaps crucially,
- the structure of, and relationship between, key organisations and agencies.

We have written separately to the Royal Commission on the interface between health and social care, and touch on topics such as breaking down barriers (between sectors, organisations and different professional groups), flexibility and responsiveness to changing needs, and the provision of seamless care. We believe that addressing these essentially organisational questions will contribute significantly to achieving the goal of 'a truly first-rate service'.

## **Service Delivery**

*Q2 How should the services be delivered?*

CCC does not advocate any particular method of service delivery. What works for one person may not work for another. For instance, CCC endorses the ethos of care in the community. However, if an individual's circumstances mean that receiving minimal care at home leaves them isolated (ie with little care or contact with the community) and therefore prone to depression, residential care might have been a preferred option.

What is critical is that, within resource constraints, the appropriate services are delivered to the service user, as far as possible in accordance with their wishes, and that the services should be responsive to changing needs. Indeed, being wedded to any one form of service delivery is likely to deny the flexibility required.

We are impressed by evidence of innovative approaches to care, for instance within the housing sector and among those concerned with preventative and rehabilitative services; the scope for technological advances (eg smart buildings), transport-related advances and the emerging willingness of professionals from different sectors and disciplines to work in partnership. Too rigid a framework of care delivery could stifle potentially beneficial innovation.

## **Direct Payments**

*Q3 Should people be given a sum of money commensurate with their care needs assessment, and invited to spend it as they wish?*

CCC is in favour of people being allocated a sum of money, commensurate with their assessed care needs, to buy recognised and regulated care provision. We believe that, as far as possible, individual choice should be what drives care provision and consequent market development. Not only do care needs and preferences vary between individuals, the needs of the individual change over time. Direct allocations would be responsive to such changes and would enable packages of care to vary, as required.

Direct allocation would also discourage resource-led perverse incentives in favour of any particular form of care, for instance as has happened in the recent past with residential care.

However, CCC is aware that a direct allocation system could be abused. For instance, money could be paid to a relative or friend who then does not provide care in return. We therefore believe that any payments, possibly vouchers, must be paid to a recognised and regulated care provider. This is the practice within the insurance industry and we see no reason why it should not also apply to the public sector. Payment or allocation for assistive devices may also be appropriate.

- Our considered view is therefore that, in practice, direct payments or allocations may be more suitable for people with severe conditions whose situation can be monitored.

Low-level care is more properly the province of informal care arrangements – which, by definition do not lend themselves to regulation. We therefore do not recommend extending direct payments to informal care. However, we acknowledge that public policy should provide incentives for informal care.

We await with interest the Government's review of the legislation covering direct payments (for under 65s) following its first year of implementation. If the lessons from that experience are that such payments are not feasible, or if the mechanisms required to counter abuse prove to be unwieldy or disproportionately costly, CCC would review its position. The question of dementia requires separate consideration.

## Who Should Provide Services

*Q4 Should the State provide the services, or should this be a free market?*

CCC believes that private, voluntary and public sector providers all have a part to play in providing services and that their strengths are complementary. What is important is that the care services are of good quality, offer value for money and are appropriate to the individual's needs, not who provides the care. CCC strongly believes in consumer choice, which can be provided by a free market, but one underpinned by necessary regulation, for which the State provides the framework.

## Setting and Enforcement of Standards: Regulation

*Q5 How can standards be prescribed and enforced? What sort of regulatory and monitoring arrangements are necessary?*

National standards should be set by a national body. Bearing in mind budgetary restraints, this would be a single agency possibly along the lines of the National Care Council advocated by the Rowntree Inquiry. We would envisage that achievable standards would be agreed by its membership, who would represent a range of expert views and include consumer representatives, and that these standards would be periodically reviewed. Dialogue should be maintained with the sources of finance for long-term care.

CCC recommends that responsibility for registration, monitoring and inspection should be vested with an independent, locally-based inspectorate. It is axiomatic that such a body should work according to the principles of good regulation, for instance as set out by the Cabinet Office Better Regulation Unit (ie accountability, transparency, proportionality, targeting and consistency), and to enjoy the respect of those they are regulating.

Regulation is, of course, only one means whereby standards are maintained. Organisational culture, management ethos and practice and training all play a part. The Government has signalled its intention to introduce a General Social Care Council; we await the forthcoming White Paper on social services before assessing its composition, structure and likely impact on standards.

*Q6 Should there be a dispute procedure, in which case who should pay, and who should adjudicate?*

There should undoubtedly be a dispute procedure, but one which is neither excessively costly nor slow and time-consuming. CCC suggests an ombudsman system, with costs borne by the State. The dispute procedure must be accessible, transparent and include provision for appeals, and access by service users to advocates, where necessary. The ombudsman must be demonstrably independent.