RURAL LENS REVIEW

People at the Heart of Care

Adult Social Care Reform White Paper

Published December 2021

RURAL SERVICES NETWORK

At a glance

Rural Services Network's thoughts on **People at the Heart of Care White Paper:**

In many places through the White Paper the Government's ambition is expressed in terms of words to the effect of "we want people to be able to say". **From a rural perspective and in terms of fairness we expect people who draw on care and support (including carers) and those delivering the support to be able to say:**

- **I and my carers can access good social care support regardless of where I live.** Addressing geographical inequality must start with the inequitable distribution of funds between rural and urban areas, including ensuring that funding formulae fully address the extra costs of service provision in the rural context.
- **I can access good social care regardless of my age.** Between 2018 and 2040 the 65+ age group in predominantly rural areas is projected to rise by 46.3% (41.2% for predominantly urban areas). For the 85+ age group the projection for predominantly rural areas is 93% (urban 66.9%). It is well known that for the 85+ age group, when care/support is needed, it is generally more complex and costly to provide.
- **I can access good social care regardless of my financial means.** I should not have to pay more through my council tax for social care in my area than someone living in an urban area.
- **I can access good digital care.** It is imperative that the necessary level of broadband connectivity required to meet the Government's aims is available across all rural areas without delay. This includes the so-called 'hard' or 'very hard' to reach areas.
- **I can access preventative health initiatives regardless of where I live**. Predominantly urban areas receive 56.8% more per head in government public health grant than their rural counterparts despite addition costs of service delivery across rural areas.

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SUMMARY

In March 2018 the then Secretary of State responsible for Health and Social Care, set out seven principles, which would "guide the Government's thinking ahead of the social care green paper". These were:

- quality and safety embedded in service provision
- whole-person, integrated care with the NHS and social care systems operating as one
- the highest possible control given to those receiving support
- a valued workforce
- better practical support for families and carers
- a sustainable funding model for social care supported by a diverse, vibrant and stable market
- greater security for all – for those born or developing a care need early in life and for those entering old age who do not know what their future care needs may be.

In response to the above the APPG on Rural Services undertook an Inquiry into the future funding of Adult Social Care in the rural context. The Inquiry was limited to England. The Inquiry's Interim Report was published in 2018 and was discussed directly with the then Care Minister. That Interim Report can be found here.

In our initial response to the Social Care Reform White Paper of December 2021 which we issued the day after the White Paper was published, the Rural Services Network welcomed the ambition of the Government in the Social Care White Paper 'People at the Heart of Care'. In particular we agreed with the Social Care Minister Gillian Keegan who stated in her speech, "We cannot be serious about Levelling Up unless we are also serious about social care".

However, we expressed concern about whether the Government will be able to deliver on their promises and fix the broken system.

The White Paper is based on 3 core principles:

1 Everybody has choice, control and support to live independent lives
2 Everyone can access outstanding personalised care and support
3 Adult social care is fair and accessible for everyone who needs it

We commented “These are bold promises from the Government and recent research by the Rural Services Network and the County Council Network, The State of Care in County and Rural Areas, highlighted particular challenges for rural and county areas which would need to be specifically addressed in order to achieve these core principles.

These challenges are:

- **Resource**: Government funded support for adult social care service costs is significantly lower in county and rural areas.
- **Workforce**: The higher average age alongside ageing population projections within county and rural areas places a high burden on these local authorities.
- **Self-Funders**: The balance of adults self-funding their care is higher in rural areas and likely to be more sensitive to reforms made to the funding system.
- **Care Homes**: The proportion of residential care homes situated in rural locations is higher than in metropolitan areas, often encouraging service user inflow to counties.
- **Sparsity**: Geographical challenges in providing adult social care in large and remote rural areas, particularly the time and costs involved in delivering personal care over large distances.

Local Authorities in rural areas are suffering from years of historic underfunding compared to urban areas. They will be looking for financial reform to bridge the funding gap for Social Care budgets to ensure that they can meet growing demands on the service and current levels of unmet need. During the Social Care Reform Statement in Parliament on 1st December, Jeremy Hunt MP, Chair of the Health and Social Care Select Committee highlighted his concerns over the lack of solutions to address the funding to local authorities for their core responsibilities and an ‘end to the workforce crisis’.

The announcements in relation to investment in a range of supported housing options, training for the social care workforce, and a practical support service to make changes in people’s homes so that they remain independent are all welcome, but need exploring in more detail to see how they will be rolled out in rural areas.

While only accounting for a quarter of service requests in county and rural areas, it must not be forgotten that nearly half of all social care expenditure is directed towards adults of working ages that require intensive levels of support. Reform needs to be balanced so its impact is felt across the whole system. Only a very small proportion of younger adults are likely to benefit from the funding and proposals announced to date.

Unless the Government provides more funding at the Spending Review to meet rising costs; expand service provision to meet needs presently going unmet; and better support younger adults, further reductions to services will be required in county and rural unitary councils in the lead up to reform.

There is a consensus across the social care sector that increased funding is needed to alleviate current pressures before future reforms can be attempted.

ABOUT THE WHITE PAPER

The Adult Social Care Reform White Paper 'People at the Heart of Care' is described by the Government as "an ambitious 10-year vision for how we will transform support and care in England".

As a vision, rather than a strategy, it is long on aspiration but short of much of the underlying detail as to how the vision will be achieved. This is probably inevitable given the 10-year timeframe. There is little detail as to which actions will be prioritised by when. It is also unclear which aspects, if any, need new or amended Primary Legislation beyond the provisions of the Health and Care Bill currently before Parliament.

Real and demonstrable improvements will need to be seen year-on-year over the 10-year timeframe, without which this could be judged as a 'kicking into the long grass exercise'.

Chapter 2 of the White Paper outlines the Government's 10-year plan for adult social care; Chapter 3 sets out a summary of opportunities the Government wants "to build on to achieve our vision". Chapters 4 – 7 then set out a number of policy chapters that "will move us towards achieving our vision".

We would stress that this White Paper is about Adult Social Care and not just elderly person's care. A review of July 2021 data shows that in respect of Personal Independence Payment for eligible working age people aged 16 to 64, as a fraction of people in this age group, the cases with entitlement stand at 6.2% in Predominantly Rural areas and 6.6% in Predominantly Urban, and the mean financial award was £111 and £109 respectively.

Therefore, disability and mental health care issues are as important in rural as urban areas – but with fewer support services available in rural areas and huge issues relating to access, isolation etc.

To quote the White Paper "Social care supports adults of all ages – including young people moving into adulthood and those of working age – with a diverse range of needs, including autistic people, people with a learning disability or physical disability, people with mental health conditions, people with sensory impairments, people who experience substance misuse, people with dementia, and other people with long-term conditions.

Care and support covers a wide range of activities to promote peoples' wellbeing and support them to live independently, staying well and safe. It can include 'personal care' such as support for washing, dressing and getting out of bed in the morning, as well as wider personalised support to enable people to stay engaged in their communities and live their lives in the way they want. This can include support to engage in work, training, education, volunteering, or support to socialise with family and friends and maintain personal relationships".

Importantly the White Paper recognises the need for the reform proposals to happen consistently so that **everyone can benefit – no matter where they live.**

RURAL ASSESSMENT

This Rural Lens Review now looks in more detail at the key White Paper proposals which could impact differentially in a rural context. It does not, therefore, aim to cover each and every issue referred to in the White Paper. In this Rural Lens Review we provide a commentary on the rural dimension on what we see as key issues and add current data where it is available. We do so in discreet sections, presented in no particular order. In some cases we utilise the Chapter Headings used in the White Paper whist in others we bring related aspects together under our own headings (e.g. Funding Related Issues). In some places in quoting from the White Paper we have emboldened certain points which we feel have great relevance in rural areas.

This Rural Lens Review builds on a joint report by the Rural Services Network (RSN) and the County Councils Network (CCN), launched in September 2021 entitled ***The State of Care in County & Rural Areas***. That report was designed to describe and quantify the then current state of adult social care in county and rural areas. Importantly, following the announcement the previous week of the Government proposals for adult social care reform in England, the report also explored the potential impact of measures on existing service provision alongside reforms such as a 'cap on care' and new rights for self-funders to access council arranged care contracts.

An Executive Summary of this joint report The State of Care in County & Rural Areas can be found here and you can download the full report here.

FUNDING RELATED ISSUES

FROM THE WHITE PAPER

1. £5.4 billion is being invested into adult social care over the next three years from the new Health and Care Levy announced in September 2021. The White Paper says that "Beyond the next three years, an increasing share of funding raised by the levy will be spent on social care in England".

2. At the Spending Review in October 2021, it was announced that this investment will be used for the following areas:
   - **£3.6 billion to pay for the cap on care costs, the extension to means test, and support progress towards local authorities paying a fair cost of care which together will remove unpredictable care costs.**
   - **£1.7 billion to improve across social care in England, including at least £500 million investment in the workforce.**

3. In this Chapter we comment on some of the funding related issues for local government. In doing so we draw on some comments from Pixel Financial Management, the RSN's Local Government Finance Consultants. Those comments are general and not rural specific.

4. The white paper starts to show **how the £1.7bn** will be used, stating:
   - At least £300 million to integrate housing into local health and care strategies.
   - At least £150 million of additional funding to drive greater adoption of technology and achieve widespread digitisation.
   - At least £500 million for the social care workforce.
   - A new practical support service to make minor repairs and changes in peoples' homes to help people remain independent and safe in their home, alongside increasing the upper limit of the Disabilities Facilities Grant (DFG) for home adaptations (£570m for DFG).
   - Up to £25 million to support unpaid carers.
   - £30 million to help local areas innovate around the support and care they provide in new and different ways.
   - A new national website to explain the upcoming changes and at least £5 million to pilot new ways to help people understand and access the care and support available.
   - More than £70 million to increase the support offer across adult social care to improve the delivery of care and support services.
   - Continue to invest in the Care and Support Specialised Housing (CASSH) funding, £210m available over the next 3 years.

5. Some of this funding has already been announced, or is for existing grants, and the values are imprecise (the phrases “at least”, “up to” and “more than” are used liberally). It suggests that ministers have yet to decide how to use some of the £1.7bn in detail.

6. The approach taken by Department for Health and Social Care also suggests that there will be new specific grants, possibly with new burdens or strings attached, and possibly with different allocation methodologies. Authorities might even find that they have to bid for some of these funds. It seems very unlikely that local government will receive any of this funding simply to use as they see fit to support existing financial pressures. As ever, ministers tend to want to attach strings to new funding.

RSN COMMENTARY:

General

Criticisms of the White Paper mainly focus on whether there is sufficient funding to make the proposals realistic – and to make social care financially viable. There is also significant concern that the White Paper fails to address the likely winter crisis and nothing to boost care worker pay in the short term amid very significant staff shortages exacerbated by the pandemic.

There is absolutely no mention in the White Paper of the formulae used to distribute Government Grant to Local Authorities. In 2021/22 urban areas receive 16% more per head of population in Government support for social care services than rural areas. The gap has increased from 4% in 2017. This is despite the fact that it costs more to provide services across rural areas.

It is imperative the Government enshrines in law the proportion of the Health and Social Care levy that will be dedicated to social care. Without a proportion of funding being enshrined in law for social care, there is no guarantee that income from the levy beyond 2025 will be used to predominantly fund social care once the NHS backlog is cleared (if it is by then).

Local Authorities in rural areas are suffering from years of historic underfunding compared to urban areas. They will be looking for financial reform to bridge the funding gap for Social Care budgets to ensure that they can meet growing demands on the service and current levels of unmet need. Simply funding the changes which are proposed is not enough. There is a huge backlog of unmet need currently which needs to be urgently addressed.

The historic underfunding has seriously impacted on the capacity of rural Councils. Competition or ‘bidding’ for Government Funds is then negatively impacted by these capacity issues.

The Government needs to ensure that all citizens are able to access the similar levels of social care service regardless of where they live. A sustainable and fair distribution of resources between health and social care must be coupled with a fair formula for distributing monies between different councils. This must recognise the costs of service delivery in county and rural areas. There must also be an understanding that reform to social care will change demand patterns and eligibility for support for self-funders, in the process creating new, specific pressures for these councils. Any funding distribution must also recognise the already disproportionate burden placed on council tax to fund services in county and rural areas.

In terms of the (at least) £150 million of additional funding "to drive greater adoption of technology and achieve widespread digitisation" the Government first needs to urgently ensure the necessary level of broadband connectivity to all rural areas – including those 'hard or very hard to reach' areas. Not to do so will clearly continue to disadvantage rural communities and exclude them from major parts of the Government's Adult Social Care Reform Agenda. Affordability of the technology, connection costs and training and support in the use of the technology will also need to be addressed as a priority. The fragility of electricity networks in rural areas also needs to be urgently remedied.

In addressing the 'Why 10 years" question the White Paper states "We know that some of the challenges in social care cannot be quickly fixed". Whilst that is true a lot of those challenges can be addressed though increased funding to meet costs (including unmet need backlogs) and – for rural areas – a fair distribution of government support which reflects the additional costs faced in rural areas.

Public and private fee polarisation has become more deeply embedded as a structural feature of the care home market, with private fees more than 40% higher than publicly paid fees for the same level of amenity, and in all probability the same level of care. Previous analysis for County Council Network has shown that this had led to a care home fee gap of £761m for counties alone in 2020/21.

It should be remembered that the underfunding by government of rural councils' costs relating to the statutory duties in respect of social care has wider service impacts. The last decade or so has shown that to fulfil their statutory duties rural councils have had to reduce other service budgets classed as 'discretionary services'. This includes bus service support, support for cultural and sports/leisure services and economic/community development. These services all impact on the wellbeing and health (physical and mental) of rural residents. Our research shows that in the current financial year (2021/22) urban authorities are able to budget to spend three times more per head of population on so-called discretionary services than their rural counterparts. Planned spend on public transport per resident is nearly ten times more in urban areas compared to rural.

Cost & Spending

- County and rural unitary councils spend 4.1 times more on social care external providers than their in-house services. This is substantially higher than in any other type of council (English unitaries 3.3 times; London boroughs 3.2 times; metropolitan boroughs - 3.0 times).

- County and rural unitary councils draw a disproportionately high amount of their fee income from client contributions compared to other types of council. Over half of all client financial contributions (charges for local authority arranged care) towards the cost of social care in England were in county and rural areas in 2019/20, some £1.5bn.

- **The data shows that the unit costs for clients aged 18-64 are most expensive in county and rural unitary councils for both residential and nursing care.** Residential care for this age group is 15% higher compared to metropolitan boroughs.

- **The cost of providing home care services in county and rural areas is significantly more expensive than for other types of council.** It is just under 10% more expensive to deliver services when compared to English unitaries and London boroughs, and as much as 18% more compared to the average metropolitan borough.

Funding & Financial Outlook

- **Between 2015/16 and 2019/20 county and rural unitary councils having absorbed substantially larger reductions to their core funding for adult social care than any other type of council (42.3%).**

- Nationally, decreases in funding have been offset to a large extent since 2017/18 by an increase in temporary grant funding. As a result of temporary grants, **all council types except county and rural unitary councils** have seen a rise in total grant funding in nominal terms, albeit small. **By contrast county and rural unitary councils have seen an overall reduction of £128m.**

- Funding and the costs of services has diverged dramatically over the past five years. As a result of growing demand for services and costs, the difference between funding and service costs has grown 20.8% over the period, some £1.2bn for county and rural unitary councils.

- Nationally government funding in 2019/20 was meeting almost 42% of the costs of providing services. There is a large variation between council types, with just 30% of costs met through grant funding in county and rural areas. **An ever-increasing reliance on council tax is unsustainable and unfair to rural areas where council tax is already much higher than in urban areas. In 2021/22 rural residents paid, on average, £96 (19%) per head more in council tax than their urban counterparts.**

- Future cost projections for the period 2020/21 to 2029/30 show that nationally total costs will rise by £6.7bn, some 38% just to keep services operating as they are presently without any increase the level or quality of services. **County and rural unitary councils account for £3.3bn of this total increase in costs over the period, with estimated spending need rising 40% - higher than the national average and for metropolitan boroughs.**

- While the additional Covid-19 expenditure on social care has been funded by Government, with this expenditure reducing by almost two thirds during the current financial year, there is growing evidence there will be medium-term 'legacy costs' from the pandemic which could become embedded beyond 2021/22. While the Government have committed to funding a 'fair price for care', it is extremely uncertain that the funding announced to date will be sufficient to meet the costs arising from reform when the full additional costs from market equalisation are considered - estimated at £761m annually in county and rural areas alone. The impact of extending commissioning duties to self-funders to enable them to have their care arranged by councils, and access local authority contracts and fee levels, must be fully costed, consulted on, and risk assessed, with appropriate funding and policy mitigation to prevent unsustainable financial costs and risks to councils and providers.

WHITE PAPER CHAPTER 1

In 2020–21 local authorities received over 1.9 million requests for support from 1.3 million new clients. In total 841,000 people were receiving state-funded long-term care in 2020–21. Demand for social care services will continue to grow as a result of better diagnosis, higher survival rates for premature babies and longer life expectancies. In addition to these long-run trends, the legacy of the COVID-19 pandemic on both physical and mental health will also contribute to future demand for social care.

RSN COMMENTARY:

Nationally it is reported that there is a backlog of care assessments and packages of about 400,000 cases.

Service Demand

- **County and rural unitary councils received 49% of all service requests in 2019/20, up by 5.6% since 2017/18. Nationally, those aged 65 and over accounted for 71% of all service requests but in county and rural areas the share of requests received from this age group is disproportionately higher (75%) compared to other parts of the country.**

- The proportion of requests attributable to older adults has remained static over the past three years, with growth in requests across the two age bands remaining broadly similarly in county and rural areas. This is in contrast to urban authorities, with Metropolitan boroughs in particular seeing the number of requests from those 65 and over decline.

- **County and rural areas have the highest percentage of service requests - 58%, where no formal service is provided. Some 545,000 requests to county and rural unitary councils during 2019/20 resulted in advice or signposting, or no service being provided. Just 8% of all requests (77,000) resulted in long-term care support.**

- The percentage of service requests where no formal service is provided has remained static since 2017/18, demonstrating that while Government have provided temporary one-off resources for adult social care, this has only served to offset rising costs of providing services, rather than expand provision to more individuals.

Care Provision

- About 80% of total gross social care expenditure (£15.4bn) by local authorities in England is spent on direct forms of care, consisting of residential, nursing, and community or home care.

- **Some 47% of spending in county and rural areas is on working age adults in receipt of care. This is despite three quarters of demand for care services in county and rural areas coming from those aged 65+.**

- County and rural spend is proportionally higher on those receiving support with a learning disability. Some 72% (£2.6bn) of provision for working age adults is for this type of care recipient, higher than in London boroughs (66%), Metropolitan boroughs (69%) and other English unitaries (67%).

- Reflecting the fact that county and rural unitary authorities contain the largest proportion of residential and nursing homes, the spend on these forms of care setting is disproportionately higher than in other councils at 52.5%.

- The data shows that there has been a long-term trend of shrinkage of the residential care home market even before Covid, with county and rural areas witnessing the closure of 272 residential and nursing care homes over the past three years.

WHITE PAPER CHAPTER 2

1. People are at the heart of our vision for adult social care. No matter where they live, their age, race, culture, religious beliefs, sex, sexual orientation, gender identity, disability, housing status or their personal circumstances. This white paper therefore focusses on people and outcomes, not just the systems behind them.

2. The starting point for our vision is embedding personalised care, which is vital to providing the user-led social care we envisage. It has been proven to improve outcomes and enhance quality of life, enabling people to take the level of control and responsibility that they feel comfortable with. Fundamentally, it recognises a person as an individual with specific needs, wishes and aims. It is our ambition to make personalisation the expected standard and for high-quality personalised care to be the norm across health and care

3. Rather than focusing on approaches to delivering care that intervene at a time of crisis, care and support services should intervene early to support individuals, helping people retain or regain their skills and confidence, and prevent needs from developing. When care supports people's independence it allows them to have real choice and control over the things that matter, enabling them to live healthier, happier, and more fulfilling lives in the place that they choose.

4. We want greater choice, control, and independence to mean that someone who draws on care and support can say:

   - I can live as part of a community, where I am connected to the people who are important to me, including friends and family, and I have the opportunity to meet people who share my interests.
   - I lead a fulfilling life with access to support, aids and adaptations to maintain and enhance my wellbeing.
   - I am valued for the contribution I make to my community and feel supported to achieve my goals.
   - I can live in my own home, with the necessary adaptations, technology, and personal support as designed by me, to enable me to be as independent as possible.
   - I have a good choice of alternative housing and support options, so I am able to choose where I live and who I live with, with the opportunities to plan ahead, and take up those options in a timely fashion.
   - I have control over my care and support, including what services I receive and how, when and where my care is provided, with access to the necessary information and advice to help me make these decisions and plan for the future.

5. We want outstanding quality and personalised support to mean that someone who draws on care and support can say:

   - I receive care and support that is safe, responsive to my needs and respects my rights.
   - I receive personalised and inclusive support, where the people who care for me know me as an individual and recognise me as having unique strengths, and aspirations and know that my background, values and requirements are unique to me.
   - I am supported by a workforce who have the right training, qualifications and values, and are concerned about what matters to me.
   - I receive care from a workforce whose careers are valued and whose professional development and wellbeing are prioritised.
   - I experience a seamless care journey, where health and care services are joined-up around me and I only have to tell my story once.
   - I receive care and support that is co-ordinated, and everyone works well together and with me to plan my care, bringing together services to achieve the outcomes that are important to me.
   - I know that if I want, I can receive help as a direct payment instead of having care services organised for me, and that I will be encouraged and supported to use my direct payment in whatever way will best suit my own needs and achieve my outcomes.
   - I can make the last stage of my life as good as possible because everyone works together confidently, honestly, and consistently to help me and the people who are important to me, including those who care for me.

6. To enable people who draw on care and support to receive outstanding quality care, government, local authorities, care providers and the wider sector will aim to make sure:
   - Safeguarding and appropriate standards of support are enforced to protect everyone receiving and providing social care.
   - Assurance is strengthened to drive up standards of care, making brilliant outcomes easier to identify and share and address areas where improvements can be made.
   - There is high-quality and timely data available nationally, regionally and locally to help identify best practice and address areas of improvement.
   - Technology is fully utilised to enable proactive and preventative care and to support people's independence.
   - Social care is recognised by the public as a valuable and high-quality service, on par with the NHS.
   - Social care is provided by a qualified, professionalised, and valued workforce, which has a low turnover to ensure continuity of care.

- All professionals involved in providing care have access to the right digitised information at their fingertips to provide safe, outstanding quality care.
- Health, social care and other services, such as housing, homelessness and community support are joined-up to provide a seamless care experience of person-led support, which also recognises and supports unpaid carers.

7. To ensure the adult social care system is fair and accessible, the government, with the support of local authorities, care providers and the wider sector, will aim to:
   - Reform how people in England pay for their care so no one needs to pay more than £86,000 for their personal care costs, alongside more generous means-tested support for anyone with less than £100,000 in chargeable assets.
   - Ensure that self-funders can access the same rates for care costs in care homes that local authorities pay, ending the unfairness where self-funders have to pay more for the same care, whilst ensuring local authorities move towards paying a fair cost of care to providers.
   - Ensure fees for care are transparent to allow people to make informed decisions.
   - Improve information and advice to make it more user-friendly and accessible, helping people to navigate the care system and understand the options available to them.
   - Provide information and advice that is accurate, up to date and in formats that are tailored to individual needs.

RSN COMMENTARY:

There is little here that can be argued with as a vision. The devil is and will be in the detail. **A timescale for what the Government wants to be achieved, by when (within the 10-year period) is essential.**

There has been criticism of how the £86,000 is to be calculated and the greater impact it will have on poorer families.

As always, our concern is to ensure that rural areas benefit from proposals at the same time and pace and to the same quality, as urban areas and that the costs of achieving similar outcomes in a rural context are fully reflected in the funding.

New statutory duties in relation to self-funders and the cap on care costs will come with significant additional administrative and workforce burdens of operating care accounts for people approaching the Councils. The implications for county and rural unitary councils will be particularly acute and will need careful consideration in the development of the Government's plans.

Analysis of the expenditure by county and rural unitary councils on different forms of setting by age group shows starkly the predominance of residential care as the primary delivery model for both cohorts above community-led services. The expenditure on residential care for working age adults is particularly marked, which partly explains the earlier finding that 47% of county social care budgets are spent on working age adults despite them only making up 33% of the total number in receipt of a service. This reliance on residential care may also be a consequence of community services being more difficult (and expensive) to provide over the long distances of rural areas.

There are benefits in a transition towards domiciliary rather than residential care, which must be managed. There needs to be a safety net for the financial risk to local authorities and the wider stability of the provider market with resultant under occupancy of residential care places. Moreover, as outlined in other parts of this Rural Lens Review, the proposed reforms present a number of further sustainability challenges from self-funders accessing local authority fee rates.

We recognise the need to address the unfairness in the fee levels paid for care. But these commitments will have enormous implications for councils and providers. The Government intention to actively encourage self-funders to access council-arranged care will lead to greater market equalisation between council and self-funder fees. **County and rural unitary councils will be particularly exposed to the risks of increased demand and greater financial pressures, given their higher average percentage of self-funders (53%) and proportion of care homes. These areas are already facing a care market-fee gap of at least £761m - the estimated annual cost of bringing local authority fees closer to self-funder rates.**

It was these costs and risks associated with market equalisation that led to the delay in the implementation of funding reforms in 2015. With financial strain in the provider market intensifying since that point, **unless significant resources are provided this would potentially further undermine the profitability of providers and result in large-scale care home closures, or unfunded commissioning costs for councils to sustain their local provider market.**

While the Government have committed to funding a 'fair price for care', it is extremely uncertain that the funding announced to date will be sufficient to meet the costs arising from reform when the full additional costs from market equalisation are considered - estimated at £761m annually in county and rural areas alone. The impact of extending commissioning duties to self-funders must be fully costed, consulted on, and risk assessed, with appropriate funding and policy mitigation to prevent unsustainable financial costs and risks to councils and providers.

STRONG FOUNDATIONS TO BUILD ON

WHITE PAPER CHAPTER 3

1. Between 2018 and 2040, the number of adults aged 85 and over is projected to increase by a further 77% (from 1.4 million to 2.4 million).

2. High quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. It is the responsibility of local authorities to ensure their local care market is healthy and diverse.

3. Several local authorities have 100% of social care services rated 'Good' or 'Outstanding', while the worst has around 65%. The government is committed **to levelling up the country and addressing this geographical inequality** so that everyone, everywhere receives outstanding quality and tailored care.

4. During the COVID-19 pandemic, the use of digital technologies transformed the delivery of care and helped people stay connected with friends and family. These digital tools supported people's care through remote monitoring, ensured care teams had the right information at their fingertips and helped services to identify those in need.

5. Although technology has been a lifeline for millions of people, it has also laid bare inequalities in access. Recent research by Age UK highlighted that the older population are still less likely to be digitally included; among those aged 75+, more than 40% do not use the internet.

6. In 2019–20, 53% of households requiring an adaption do not have all the adaptations needed, a rise from 45% in 2014–15.

RSN COMMENTARY:

Between 2018 and 2040 the 65+ age group in predominantly rural areas is projected to rise by 46.3% (41.2% for predominantly urban areas). For the 85+ age group the projection for predominantly rural areas is 93% (urban 66.9%). It is well known that for the 85+ age group, when care/support is needed, it is generally more complex and costly to provide.

As we said in the previous section unless significant resources are provided proposals in the White Paper would potentially further undermine the profitability of providers and result in large-scale care home closures, or unfunded commissioning costs for councils to sustain their local provider market.

We cannot stress enough the need to invest in, grow and encourage micro-enterprises in very local rural areas and ensure these micro-providers meet the quality standards and safeguarding required. These requirements at present create a barrier to entry that ends up with large care provider companies dominating the market but operating a business model that adds to the cost of delivering to rural areas - if they do so at all. Micro enterprise needs to be factored into procurement practice or we will continue to have care provider contracts handed back in large rural areas.

Addressing geographical inequality must start with the inequitable distribution of funds between rural and urban areas, including ensuring that funding formulae fully address the extra costs of service provision in the rural context.

As we have commented elsewhere in this Rural Lens Review it is imperative that the necessary level of broadband connectivity is available across all rural areas without delay. This includes the so-called 'hard' or 'very hard' to reach areas.

WHITE PAPER CHAPTER 4

1. Wherever possible, care and support should be in a person's own home and personalised in line with their specific needs, although recognising that not everyone has a home of their own, and sometimes specific needs are best met in a supported living or care home setting.

2. A recent survey by the Social Care Institute for Excellence asked, "which of these things would be most important to you if you need or needed care or support?" and the top three priorities were: 1) remaining independent, 2) having access to the internet, phone and technology and 3) being able to stay in my current/own home.

3. We want people, wherever they live, to have choice over their housing arrangements.

4. This means putting practical digital tools in the homes and the hands of those who draw on care and support and their carers; equipping the social care workforce with the digital tools, knowledge and confidence they need to deliver outstanding quality care; and creating the digital and data infrastructure needed to drive future transformation in care delivery.

5. Ensuring that people receive the right care and support all begins with where they live, and the people they live with.

6. A lack of suitable housing options results in too many people staying in hospital unnecessarily, or moving to residential care prematurely even if that is not what they want, instead of recovering at their own home.

7. To realise the ambition, we set out we need to ensure that "every decision about care is also a decision about housing".

8. We first need to embed a series of enablers:
   - Strong leadership and partnership: No organisation can deliver this change alone. Change requires collaboration across commissioners and providers of health, adult social care and housing, and homelessness support services, as well as local planning functions and voluntary organisations. Underpinning them all is the need for strategic leadership that sees the local provision of health, care and housing services not as separate systems, but as a coherent system that seeks to deliver the

best outcomes for people, using all the tools available in a joined-up way to deliver the best possible outcomes for their communities.

- Long-term funding certainty: Housing providers need to take decisions on where and when to invest that look decades into the future, confident that people will be supported to live in those homes for many years to come.
- Wider influence: Housing that better meets future care and support needs must be delivered within a complex wider housing market. For changes to be embedded we need to influence beyond the adult social care system.

9. We also need to actively shape the specialist housing market – to establish and consolidate local strategic leadership and create the right incentives for local areas and housing providers to invest, including in new and innovative models of provision. We will therefore invest at least £300 million for the period 2022–23 to 2025–26. This new investment will allow local authorities to deliver the vision set out in this white paper by integrating housing into local health and care strategies, with a focus on boosting the supply of specialist housing and funding improved services for residents. This in turn will drive increased confidence in the social supported housing market, stimulating a positive cycle of further innovation and private investment.

10. To achieve this there will be a critical role for Integrated Care Partnerships (ICPs) in driving the necessary integration of housing within health and care, both through the development of local strategies and in the delivery of services. The upcoming integration white paper will set out more detail of how we will support local places, working with ICPs and Integrated Care Boards (ICBs) to deliver effective joined-up care.

11. The intention is that over the three- year period 2022/23 – 2025/26 the new investment (of at least £300m) will:
    - Enable all local areas to agree a plan embedding housing in broader health and care strategies, including investing in jointly commissioned services.
    - Boost the supply of supported housing, coupled with driving innovation in how services are delivered alongside housing where possible.
    - Increase local expenditure on services for those in supported housing.

12. There is evidence that for both working age adults and older adults, supported housing can be the best model of care to provide better health, greater independence, as well as closer connection with our friends, family and community. In addition, supported housing can be better value than institutional care (e.g., residential care) which is often more intensive, and so there is the potential to reduce costs to the health and social care system.

13. As far back as 2015 in the publication of the Building the right support national plan, supported housing was identified as an important way to improve outcomes for autistic people and people with a learning disability and prevent people from ending up in inpatient mental health settings. Yet the fact is we do not have enough supported housing to keep pace with demand, and we are not building enough to close that gap. An important priority for the government in achieving our 10-year vision is therefore to grow investment in both grant-funded and private supported housing to incentivise their supply.

14. We will continue to invest in the Care and Support Specialised Housing (CASSH) Fund, with £70 million per year capital funding available per year between 2022–23 to 2025–26, to incentivise the supply of specialised housing for older people and people with a physical disability, learning disability, autism, or mental ill-health. This is in addition to the Department for Levelling Up, Housing and Communities' Affordable Homes Programme (AHP) 2021–26 which will continue to support the delivery of support housing. We will work with Homes England and The Greater London Authority to ensure that CASSH is well targeted and is easy for applicants to access and navigate.

15. We want more people to benefit from home adaptations to meet their needs, and therefore we will commit a further £570 million per year (2022–23 to 2024–25) to provide funding to local areas to deliver the Disabled Facilities Grant (DFG). Government is publishing updated DFG guidance to advise local authorities in England how they can effectively and efficiently deliver DFGs to best serve the needs of local older and disabled people.

    - We are increasing the amount that the grant can pay for an individual adaptation. This will bring mean that more people who need the grant across the country will be able to access it. We will publicly consult on this change in 2022.
    - We will look at the way DFG funding is allocated to local authorities. This will help ensure better alignment with local demand so that more adaptations reach those who need them most. The government will consult on a new approach in 2022.
    - We are also funding a new service to make minor repairs and changes in peoples' homes. These small repairs and changes in peoples' homes can help them stay safe and independent and reduce demand for more substantial adaptations through the DFG.
    - We recognise that the means test underpinning the DFG is complex and can be difficult to navigate. We will therefore be considering how best to align the means test with the charging reforms. We will publicly consult on this change in 2022.

16. The Department for Levelling Up, Housing and Communities has consulted on options to raise the accessibility of new homes, recognising the importance of suitable homes for older and disabled people. We are currently considering responses and will publish a government response setting out next steps in due course.

17. We want to support the growth of a thriving older peoples' housing sector, that builds enough homes to match growing need, gives certainty to developers and investors, and empowers consumers with choice from a diverse range of housing options to suit their needs

RSN COMMENTARY:

Research by the Nuffield Trust in January 2019 showed that was an almost 40% increase in delayed hospital discharges (delayed days per 1,000 admissions) by Trusts defined as "with unavoidably small hospitals" compared to other Trusts. Resolving the care crisis in rural areas would reduce NHS costs and cut waiting lists for NHS care.

Suitable housing will always be a key factor in the development of adult social care. In its report with the Association of Retirement Community Operators (ARCO) - Planning for Retirement - CCN highlighted the desire of many of its members to invest in retirement communities which can offer a more gradated and preventative approach to ageing within specifically designed housing with care developments.

The Government states that it wants people to be able to say, **"I can live as part of a community, where I am connected to the people who are important to me, including friends and family, and I have the opportunity to meet people who share my interests."** The development of suitable homes for older and disabled people in or near to their family home is massively important. The costs of such small-scale developments must be fully recognised as must the costs of meeting the care needs of residents in those developments.

The report recommended that a key barrier to expanding this provision at present is the large number of terms being used to describe 'Retirement Communities' (e.g., 'Extra Care', 'Close Care', 'Later Living' etc.) makes it confusing for different local authority functions (e.g., housing, planning, social care) to always be clear on what they are talking about to each other. Creating more common language to define what a retirement community is and what it should offer would be helpful.

Another recommendation would be to ensure that classifications in the planning system properly reflect the fact that the retirement community model is neither C2 (Residential Care) or C3 (Private Retirement Housing) but somewhere in between. The report therefore recommends the creation of a new C2R category with clear definitions of what would be expected from a retirement community which could provide greater assurance for councils, providers and developers alike and make the creation of such developments more likely.

There is a clear lack of housing choice for older households in the rural areas where they live. There are no real options to 'right-size' given limited growth in new developments.

There are significant challenges in adapting older homes for disability living.

A high proportion of older owner and occupiers are reliant on community support.

Access to DFGs is challenging for many and grant rates too low – the whole approach to adaptations needs overall. Ultimately prevention through the right adaptations could prevent falls etc. thereby reducing NHS/Social Care costs.

To help support the expected ongoing transition from residential to domiciliary care, reform should help encourage the better development of mixed forms of provision such as retirement communities which offer specifically adapted housing with care on site enabling a more gradated approach to planning for infirmity and meeting the care needs of those who are ageing.

The Government must ensure that Registered Providers (Housing Associations) and Housing Authorities can play their full part by making grant rates (including via Homes England) reflective of rural development costs. **A bespoke rural grant fund is called for.**

Even if the £300m of funding referred to was all put into new build developments it would deliver just 3,000 new homes across England at £100,000 per unit (which may well be a low estimate of combined land, design, infrastructure and build costs).

The White Paper makes much of embedding housing in broader health and care strategies. In rural areas the problem is also the other way around and comes from not embedding health and care into broader housing and planning strategies. If planning, housing and economic strategies continue to encourage working people to live in ever-expanding major settlements and leave rural communities to be the preserve of older people, the costs of care, especially when care costs are capped (if this can really be said to be happening) will fall to the public purse. It will also be even more expensive because the workforce will not come from within the community. This is a major contributor to the workforce challenges.

DIGITALLY ENABLED CARE

WHITE PAPER
1. We must ensure that technology reduces rather than exacerbates loneliness and isolation, and that it supports the mental health and well- being of people and carers. 2. We have developed a 10-year vision for what a digitally enabled social care system would look like. 3. it needs to be as easy as possible for people to purchase and use the technology that would best support their goals. 4. We already have work underway to understand the telecare sector's readiness for the digital switchover, which will switch all analogue phone lines across the country to digital connections by 2025. 5. Refers to the Buurtzorg model, founded in 2006 in the Netherlands by a small team of professional nurses. The model integrates health and care services. It involves small, autonomous, neighbourhood- based teams that provide a range of care and support services to people in their homes, building a care and support plan around a "self-managing" client, involving the person's informal and formal support networks. Local authorities and providers are also establishing different ways of delivering care to their population. 6. We will invest up to £30 million in a new 'Innovative Models of Care' programme. The Programme will provide the vehicle for local areas to come together to trial and embed ambitious new services for addressing key priorities such as prevention, reablement, better support for unpaid carers (for example, through respite provision), or key enablers such as local community capacity building or outcomes - based commissioning for improved outcomes. 7. The programme will support local authorities and partner providers to develop, commission and deliver new models of care for people living in non-residential settings. We are designing the programme in consultation with the sector to ensure it addresses the key barriers to embedding innovation. As part of the programme, we intend to convene innovation partnerships, based on a number of agreed innovative models. These will provide expert support, building local authority and provider capacity, skills and knowledge sharing into the process.

8. Alongside this, we will provide risk-sharing funding to a number of local authorities to mitigate the additional costs arising from system change as well as business development support to care providers to build capacity in the sector.

9. The newly formed Office for Health Improvement and Disparities (OHID) gives increased focus on improving the health of the population, working across government departments to co-ordinate efforts and impact. OHID will focus the whole health family on delivering greater action on prevention; and – working with a new cross-government ministerial board on prevention – drive and support the whole of government to go further in improving health and tackling health disparities, address the wider drivers of good health, from employment to housing, education to the environment.

10. OHID will tackle the top preventable risk factors for poor health, including obesity, smoking and alcohol. Improving quality of life in the last 5 years of life will enable older people to do what they have reason to value, for example, work, caring or volunteering, as recommended by the World Health Organization in its Healthy Ageing Strategy.

RSN COMMENTARY:

To repeat a point, we made earlier in this Rural Lens Review, in terms of the (at least) £150 million of additional funding "to drive greater adoption of technology and achieve widespread digitisation" the Government first needs to urgently ensure the necessary level of broadband connectivity to all rural areas – including those' hard or very hard to reach' areas. Not to do so will clearly continue to disadvantage rural communities and exclude them from major parts of the Government's Adult Social Care Reform Agenda. Affordability of the technology, connection costs and training and support in the use of the technology will also need to be addressed as a priority.

DHSC needs to be very clear where the greater adoption of technology and widespread digitisation can be achieved through Super- Fast Broadband (rather than gigabit capable) and communicate that widely throughout rural communities and to service providers.

The fragility of electricity networks in rural areas also needs to be urgently remedied.

When considering the new 'Innovative Models of Care programmes and providing 'risk-sharing funding' **it is essential that a number of rural local authorities are involved to develop and share best practice in the rural context.**

In respect of the Office for Health Improvement and Disparities "tackling the top preventable risk factors for poor health, including obesity, smoking and alcohol" it should be noted that **in terms of prevention activities relating to Public Health generally predominantly urban areas receive 56.8% more per head than their rural counterparts despite addition costs of service delivery across rural areas.**

WHITE PAPER CHAPTER 5

1. Overview of Main Policies:
   - Invest at least £5 million to test and evaluate new ways to help people navigate local adult social care systems.
   - A national website providing information and simple explainers about adult social care reform.
   - Invest up to £25 million to work with the sector to kick start a change in the services provided to support unpaid carers.
   - A new obligation for Integrated Care Boards and NHS England to involve carers when commissioning care for the person they care for.
   - DWP will launch Local Supported Employment to identify effective ways local authorities can support autistic people and people with learning difficulties into employment.
   - BEIS will introduce a Carer's Leave entitlement of 5 days of unpaid leave per year for eligible employees.

2. We have designed, with stakeholders, a package of measures for the next three years. It targets those challenges identified as the highest priority to improve the current information and advice system. The package has three principles:
   - Everyone should be aware of basic information about adult social care and the upcoming reforms to the system.
   - People should have access to personalised advice about adult social care when they need it.
   - There should be oversight and accountability of information and advice services.

3. We will create a national website providing information and simple explainers about adult social care reform for the public, to be launched this year.

4. Personalised advice is best delivered locally, so it can link to services and support that are available in a particular area. We will therefore provide dedicated funding worth at least £5 million over three years to local organisations to pilot and evaluate new ways to provide personalised advice to help people navigate local adult social care systems.

5. We will consider changing Care Quality Commission Regulations (2009) to require CQC-registered providers to be more transparent about their fees.

6. We will invest up to £25 million to work with the sector to kick start a change in the services provided to support unpaid carers. We expect that this funding will identify and test a range of new and existing interventions that support unpaid carers, which could include respite and breaks, peer group and wellbeing support, and new ways to combine these to maximise their impact.

7. People with disabilities face particular barriers in the labour market, and autistic people and those with a learning disability face heightened challenge. The employment rate for autistic people is 26.5% and 25.6% for those with a severe or specific learning disability, which compares with 52.7% for the disabled population as a whole. For people with a learning disability receiving long term social care support the rate has been around 5–6% for many years (5.1% in 2020–21). Autistic people and people with a severe learning disability often find it hard to navigate recruitment processes, to demonstrate their skills before starting a job, and can need support settling in to work.

8. DWP will now fund a Local Supported Employment scheme, working with 20 local authorities, expected to begin in 2022. The initiative will support approximately 1,200 participants with a learning disability or autistic people who use local authority social services.

RSN COMMENTARY:

We repeat the points made before about the reliance on digital technology in the rural context.

The identification and testing of a range of new and existing interventions that support unpaid carers must include identification and testing in a rural context.

The DWP Local Supported Employment scheme must include at least 2 rural local authorities as part of the 20 to be worked with.

A few hours may be a useful period of respite for a carer living in a large town where they can do useful things in a few hours. For a carer - who may not drive - in a rural village, a few hours is the time spent sitting on the bus get to do something useful. As such more time is needed for respite care to be meaningful in rural areas.

WHITE PAPER CHAPTER 6

1. We are investing at least £500 million over the next three years to begin to transform the way we support the social care workforce. This dedicated investment in knowledge, skills, health and wellbeing and recruitment policies will improve social care as a long-term career choice.

2. Overview of main policies
   - At least £500 million to transform the way we support and develop the workforce including:
   - A Knowledge and Skills Framework (KSF), career pathways and linked investment in learning and development to support progression for care workers and registered managers.
   - Funding for Care Certificates, alongside significant work to create a delivery standard recognised across the sector. This will improve portability, so that care workers do not need to repeat the Care Certificate when moving roles.
   - Continuous Professional Development (CPD) budgets for registered nurses, nursing associates, occupational therapists, and other allied health professionals.
   - Investment in social worker training routes.
   - Initiatives to provide wellbeing and mental health support and to improve access to occupational health.
   - A new digital hub for the workforce to access support, information and advice, and a portable record of learning and development
   - New policies to identify and support best recruitment practices locally.
   - Exploration of new national and local policies to ensure consistent implementation of the above, as well as higher standards of employment and care provided.
   -

3. The Government wants someone who works in adult social care to be able to say:
   - Social care is a rewarding career with clear opportunities to develop and progress, and where I feel valued in my role.
   - I feel recognised for the important role I play in helping people who draw on care and support receive high-quality, personalised support that enriches their lives.
   - I feel recognised for my existing skills and am able to develop new skills and take on new challenges as I become more experienced.
   - There is a culture in my workplace that supports my health and wellbeing.

- I have the confidence to use technology that supports people's needs and frees up time to deliver outstanding care.
- I am able to work effectively with professionals from other organisations including the NHS, housing and community services, learning from each other's practice and supporting each other to achieve shared goals.

4. We will also invest in hundreds of thousands of training places and certifications to enable the workforce to develop and progress within the KSF now and in the future, building on existing skills and expertise.

5. We will continue to ensure that high-quality apprenticeships meet the skills needs of social care employers and provide people of all ages and backgrounds with the opportunity to benefit.

6. The new national KSF will be accompanied by a funded learning and development offer, creating opportunities for the workforce to become experts in their field or progress into new roles.

7. Our new wellbeing and occupational health offer aims to provide immediate relief from burnout, trauma, and mental illness. We want to work with local authorities and care providers to reduce mental and physical sickness and develop a more positive experience for everyone working in social care.

RSN COMMENTARY:

Analysis by the Nuffield Trust suggest that nationally 110,000 people could lose out on home care by April 2022 due to staff shortages fuelling what it describes as 'an invisible care crisis' in people's own homes and increasing burdens on unpaid carers

Rural areas already faced challenges recruiting and retaining carers before the pandemic, given the need to deliver over larger areas. Some providers do not always fund travel time for domiciliary carers, for example, which can be distinctly longer in remote rural or coastal areas, and these disincentives workers. Some people who would be suitable to work in social care may not have access to their own transport and public transport is infrequent or even non-existent in areas outside of main conurbations.

The absence of truly affordable homes in rural areas (to rent or buy) unquestionable affects the number of potential employees. If, due to housing costs/availability, people leave rural areas for market town or other larger centres the cost of travel to work is a disincentive to employment in the rural care sector at present.

More recently, additional pressures in the workforce have been created by labour shortages in other industries such as hospitality, catering, and retail which often draw from the same pool of workers. Pay inflation in these roles has had a significant impact on the sector as care workers are enticed away by more pay with less responsibility elsewhere.

As part of their proposals for reform, the Government have outlined that they will invest at least £500m in new measures to provide support in developing the workforce and introduce further reforms to improve recruitment and support for our social care workforce.

CCN and RSN welcome the emphasis on improving the workforce. However, the details of proposal must recognise the particular challenges faced in county and rural areas and ensure that the workforce is adequately recognised and rewarded. This may involve specific policies tailored to meet rural circumstances. Resources must allow county and rural unitary councils, which have difficulty recruiting staff to work across long distances, to be able to compete with industries such as hospitality and retail which draw from the same labour pool and which have recently witnessed pay inflation.

WHITE PAPER CHAPTER 7

1. Overview of main policies:

   - From 2022 to 2025, we will provide £3.6 billion to reform the social care charging system, enable all local authorities to move towards paying providers a fair rate for care and prepare local care markets for implementing reform.
   - We will provide more support to local authorities, including specific support to strengthen their market shaping and commissioning capabilities. In total we will provide an increase in improvement funding of more than £70 million between 2022–23 and 2024–25, to ensure that local authorities are well set up to deliver our vision for reform.
   - We will introduce a duty for the Care Quality Commission (CQC) to independently review and assess local authority performance in delivering their adult social care duties under Part 1 of the Care Act 2014.
   - We are putting in place new legal powers for the Secretary of State for Health and Social Care to intervene in local authorities to secure improvement where there are significant failings in the discharge of their adult social care functions under Part 1 of the Care Act 2014.
   - Establish an adult social care data framework by spring 2022 and improve the quality and availability of data nationally, regionally and locally.

2. We will provide £3.6 billion to reform the social care charging system and enable all local authorities to move towards paying providers a fair rate for care. **Further details will be announced shortly.**

3. We know creating an effective market is challenging and we want to provide more support for local authorities to do this.

4. We will also include more bespoke support to help tackle particular problems that local authorities might be facing such as the additional work on market shaping and commissioning described above. Through this bespoke offer, local authorities and other local partners will be able to request additional expert support to develop and apply universal tools that will help them on specific issues they are facing challenges with. We will begin rolling out this offer during 2022/23.

5. In partnership with providers, local authorities and their partners, we will review current data collections and publications, ensuring they have a clear purpose and are proportionate, and fill remaining data gaps to ensure we have robust data flows.

6. There is a lack of data and evidence on the extent to which care needs are not being met. Estimates of unmet and under met need vary considerably depending on the definition used. For example, definitions that include people with lower level or one-off needs are significantly higher than a definition more closely aligned to that established by the Care Act 2014. There is also limited evidence on the drivers of unmet need, but we know these can be broad, from a lack of awareness of entitlement and options to not wanting to ask for more help or a lack of confidence to ask for help. Truly tackling issues around access to care requires an understanding of the extent to which the various drivers apply and what works in addressing them.

7. Of the 1.9 million requests for support in 2020-21, 0.5 million resulted in 'universal services/signposting to other services'. Universal services are defined as any service or support for which national eligibility criteria (following Care Act 2014) are not relevant. It includes the provision of information and advice. 'Signposting' indicates that the client will not be supported by the local authority and there is no universal service which will help them. Details are therefore given of other organisations (e.g., in the voluntary sector) that might be able to provide assistance. Source: Adult Social Care Activity and Finance Report 2020/21

RSN COMMENTARY:

See the Funding Related Issues in this Rural Lens Review.

In terms on new duties for the CQC there should be a requirement for the CQC to reach a judgement when reviewing the plans and strategies of ICSs and ICBs in respect of 'fair and reasonable access to services' for different communities (including rural) across the service geography.

ICBs and ICS must be required, in law, to collaborate with their neighbours over rural areas where services straddle their boundaries.

In terms of data collection, the requirement should be of sufficiently fine grain to identify the situation in different rural communities.

WHITE PAPER CHAPTER 8
1. The measures we have announced will bring tangible benefit to the lives of people who draw on care and support, their families, and their carers; moving us towards our 10-year vision of person-centred care where people are offered choice, control and support to lead an independent life; people can access outstanding quality care and tailored support; and people find adult social care fair and accessible. 2. We will work with local authorities, housing providers and others to agree how we will target our new investment in housing and to design our new Innovative Models of Care Programme that will support local places to bring proven innovations from the margins to the mainstream. We will be consulting on the detail of the changes to the upper limit for the Disabled Facilities Grant (DFG). 3. We will publish a social care technology blueprint, as well as developing advice on 'what good looks like' for social care technology. 4. On unpaid carers, our immediate focus will be on working towards the development of the new funded proposals. Taking an evidence driven approach, we will target a range of projects on a 'test and learn' basis. We will develop the focus with carer organisations, carers, commissioners, academics, and others in the sector to ensure we learn from the most effective ways to support carers, for example, through new multi-dimensional support models. We are in the process of developing an overarching evaluation framework.