Care at home: challenges, possibilities and implications for the workforce in Wales – summary report

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May 2010

Further copies and other formats
Further copies and other formats of this document are available in large print or other formats, if required.
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ACKNOWLEDGEMENTS

Thanks are due to the Care Council for Wales in commissioning this study and providing direction at the outset. We would like to recognise the role of Toni Leggett at the beginning of the process, and Gerry Evans, Sioned Williams and Sheila Lyons - all of the Care Council for Wales - in managing the project and assisting the study throughout. In addition the role of the Project Steering Group has been crucial in ensuring the research has remained grounded in the realities of care at home, and for providing rigorous and appropriate challenge where required.

As with any such research, this project was only possible thanks to the contributions of the participants - their willing engagement with the study, openness and honesty is gratefully acknowledged. The number of participants stretches into the hundreds - whether service users, carers, front line care workers, direct service managers, other managers, commissioners or other stakeholders - and we wish to acknowledge their role. We hope that the engagement of these individuals throughout the process has given it a rigour and reality check that is welcomed by all.

The report provides the Care Council for Wales, Welsh Assembly Government, local authorities, care at home providers and other key stakeholders a series of recommendations about the future of care at home. These are based on our interpretation of the evidence presented to us by participants and the extant data. The report offered here is entirely our own and any errors of interpretation are solely due to the authors.

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May 2010
ABOUT THIS REPORT

Purpose

The purpose of this Summary Report is to provide a brief overview of the most important research findings, conclusions and recommendations which emerged as part of the Care at Home study. It is a companion to the Final Report, a document which provides considerable detail on the study as a whole.

The Final Report, and more information about the study can be downloaded from the Care Council for Wales’ website (www.ccwales.org.uk) or obtained from Sheila Lyons, Project Manager for the Care Council for Wales (sheila.lyons@ccwales.org.uk). The document and further information can also be accessed from the Welsh Institute for Health and Social Care’s website (http://wihsc.glam.ac.uk) or Dr Mark Llewellyn (mrllewel@glam.ac.uk), the research team Project Manager. Wherever possible we have tried to link the two reports together - the Appendix of this report, for example, summarises the case studies and interesting practice examples from the Final Report.

Methodology

The study began in Autumn 2008 and the findings, conclusions and recommendations summarised here are the culmination of much information gathering over 18 months. We employed a mixed methodology which engaged closely with the experiences of the workforce and those they serve which included the following:

- Desk top research and literature review culminating in a Scoping Report (Autumn/Winter 2008-9); ¹
- Workforce Visioning Event with sector representatives to guide initial thinking on key themes and areas for consideration (Spring 2009);
- Primary research (interviews, discussion groups and questionnaires) with 160 service users and carers, 119 front line care workers and their direct line managers/supervisors; and 17 other stakeholders - service managers, commissioners and representatives of local and national organisations, charities and voluntary sector bodies (Summer 2009);
- Four Deliberative Workshops focusing on the key themes that had emerged (Autumn/Winter 2009-10); and
- Developing a ‘Your View’ document which reflected back to nearly 300 participants the research findings and afforded them an opportunity to comment. The outcomes from that exercise have been reflected in the Recommendations made here (Spring 2010).

Remit of the Care at Home Study

The Welsh Institute for Health and Social Care, University of Glamorgan with Insight Social Research and The Management Standards Consultancy were commissioned by the Care Council to undertake a study on the care at home workforce and the implications for the workforce of moving towards new ways of working. In short, the project was commissioned to answer three key questions:

1. What does the care at home workforce currently look like?
2. What is the future vision for care at home and its workforce?
3. What do we need to do to move the current workforce towards the vision?

This document tries to answer each of these three questions.

The approach taken by the research team to address the remit was a broad and inclusive one:

- including working across different client groups: acute and chronic illness, frailty, learning disabilities, mental health and physical disabilities and sensory impairment;
- understanding the reasons for variation in challenge: age, gender, complexity of need, ethnicity, rurality, language of choice etc;
- fully exploring the realities of care at home: research with service users, carers and care workers, as well as those that manage, assess and commission them;
- responding to issues raised by the Project Steering Group: procurement and commissioning, recruitment and retention, training, qualifications, resources, data, policy.

Throughout the study, the Project Steering Group took an active role in decisions regarding the methodology and overall direction of the work.

### SETTING THE CONTEXT

#### WHAT DOES THE CARE AT HOME WORKFORCE CURRENTLY LOOK LIKE?

By way of introduction and in order to set the context it is useful to reflect on the current challenges and pressures in providing care at home in Wales. There are a hugely complex set of interactions needed to ensure that the 11.7 million hours of care at home delivered by an estimated 15,500 care at home staff to 25,000+ service users in Wales is sustainable and of high quality. This is in addition to the nearly 300 million hours of unpaid care provided by carers. The diagram (Figure 1) on the following page provides an illustration of the strategic challenges and operational pressures currently facing care at home services across Wales to ensure services are provided as efficiently and effectively as possible.

#### WORKFORCE DATA AND INFORMATION

The agencies that provide care at home in Wales are substantively regulated, and registered with the Care and Social Services Inspectorate Wales (CSSIW). In terms of regulations the key reference points are the Care Services Act 2000 (and its various versions), the Registration of Social Care and Independent Health Care (Wales) Regulations 2002, and the Domiciliary Care Agencies (Wales) Regulations 2004 (National Assembly for Wales, 2004). These set out what is included and what is excluded and, by so doing, determine the current boundaries for domiciliary care in Wales. Included in the definition is ‘personal care’ which involves:

> ‘assistance with bodily functions such as feeding, bathing, walking and toileting; and care which falls just short of assistance with bodily functions, but still involving physical and intimate touching.’

In addition the Welsh National Minimum Standards clearly seek to underpin domiciliary services that ‘work with’ rather than ‘do for’ service users.

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2 When used in this report ‘care workers’ refers to the paid workforce (in either the public, private or third sector), and ‘carers’ refers to unpaid individuals - typically family, friends or neighbours - who provide care to people.

Figure 1 | Current challenges and pressures facing care at home services in Wales

<table>
<thead>
<tr>
<th>Policy Context</th>
<th>Service Financing, Commissioning and Assessment</th>
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<tr>
<td>To promote independence and empower service users to remain at home for longer.</td>
<td>Tighter budgets and cost savings increasingly important plus implications of Paying for Care / Social Care Charges Measure.</td>
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<tr>
<td>Collaborate with others effectively and improve leadership across health and social care.</td>
<td>Thresholds for care continually rising coupled with limited investment in prevention.</td>
</tr>
<tr>
<td>Investigate new models including the role of technology.</td>
<td>Challenge of demographic changes and new types of worker / service models emerging.</td>
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<td>Invest in a flexible, valued and regulated workforce.</td>
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<th>Service Users</th>
<th>Carers</th>
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<tr>
<td>Getting older with specialist and more complex needs for longer.</td>
<td>Vast majority of care is provided by carers (95%+)</td>
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<tr>
<td>Increasingly wanting to be more and more involved in decisions.</td>
<td>Mounting pressure to respond to changing circumstances - balancing work, family and caring role.</td>
</tr>
<tr>
<td>Faced with services and processes that leave them feeling disempowered.</td>
<td>Legislative Competence Order intended to support carers more effectively.</td>
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<th>Providers</th>
<th>Workforce</th>
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<td>Low pay and status = recruitment/retention problems.</td>
<td>Often don’t feel valued - no professional registration.</td>
</tr>
<tr>
<td>Increasing requirements for different mix of specialist and generalist skills - support for frontline management?</td>
<td>Need to develop new skills and enhance existing ones.</td>
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<tr>
<td>Significant time pressures on being able to deliver care.</td>
<td>Qualification levels and career pathways not clearly identified.</td>
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<td></td>
<td>Problems of data - how many workers, how well skilled?</td>
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Sustainable, high quality home care?
It is important to recognise that the care at home workforce is not homogeneous, in the way it is in the NHS with one employer a clear structure and control system. It is a workforce employed across the 354 separate agencies registered with CSSIW across the public, independent and third sector. Each agency is unique and trains and manages its own workforce to meet the specific terms of contract commitments they have at any one time. The size of agencies varies from typically 20-50 workers in small private agencies through to over 200 workers in public sector services. The workforce is therefore highly fragmented.

Further it is essential to understand how difficult it is to gather accurate data across the whole of the sector. There are real challenges in determining up to date information about the workforce - less so for workers in the public sector - but the situation is far from satisfactory. The following paragraphs summarise the best information available.

**Care at home agencies**

On 31st March 2009 there were a total of 354 domiciliary care agencies registered with CSSIW compared to 340 in 2008 which represents a 4% increase in agencies. The provider type data indicates a small increase in independent sector providers in 2009 (1%) and independent provision is currently operating at 87% and local authority at 13%. These percentages do not reflect the actual level of service delivered by the public sector as CSSIW only records the size of the agency and not the overall extent of the provision. There has also been an increase in the number of domiciliary care agencies providing in excess of 200 hours personal care per week. Over 90% of providers have appropriate quality assurance systems in place that meet requirements and there has been an improvement in how the views of service users and their relatives are incorporated.

**Workforce and service delivery data**

The latest publications from the Local Government Data Unit and Statistics for Wales report that Wales spent £1.3 billion on personal social services from April 2008-March 2009. Other key data from these reports include that in 2008-9:

- The total whole-time equivalent (WTE) number of staff directly employed by social service departments was 20,241, a decrease of 1% compared to 2007;
- Home care staff made up 22% of the WTE of the social services workforce. There are 6,857 home care staff employed by the public sector in Wales of whom 5,755 work part-time. This equates to a WTE of 4,455;
- The overall proportion of public sector home care staff holding a required or recommended qualification was 48%, compared to 44% in 2007;
- 14% of public sector home care staff are reported as Welsh speakers, and able to conduct their work through the medium of Welsh;
- Local authorities assessed the needs of 90,700 people and at 31st March 2009 there were 81,500 adults receiving social services;
- 1,991 people received a direct payment;
- Almost three-quarters (73%) of people receiving services were older people, aged 65 or over. Nine in ten users under 65 years old received community-based services compared to 72% for those aged 85 or over;
- People with physical and sensory disability/frailty accounted for 74% of clients;
- 25,685 people received home care;
- Total home care hours provided by local authorities decreased by 4% to 11.7 million hours - 56% of these hours were supplied under contract by the independent sector, and consequently 44% by the public sector;
- During a sample week in September, 23,600 people received home care, a fall of 4% compared to the previous year, with the largest decrease in the number of people receiving less than five hours of care.

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Independent sector workforce data

In its most recent ‘Overview of the Domiciliary Care Sector’ the United Kingdom Home Care Association (UKHCA) - a representative association for organisations that provide domiciliary care, home nursing and allied services - notes that in 2001 there were an estimated 6,000 homecare workers in the independent sector and that since then very little information has been collected on the independent sector homecare workforce in Wales. In 2001, 44% of services were provided by the independent sector, and this proportion has grown to 56%. Based therefore on these data and on the proportion of staff to hours of care delivered it is possible to extrapolate the numbers of workers in the independent sector to 8,727 - giving for the purposes of this report an estimated 15,584 workers across the independent and public sector agencies.

Carers

The 2001 Census collected information regarding the numbers of carers in the UK and the amount of caring they do for the first time. Based on returns, Carers UK recorded that there are nearly 6 million carers in the UK, with 340,745 in Wales - equivalent to 11% of the Welsh population. It is possible to analyse these figures and make an evidence-based judgement about the proportion of care in Wales that is paid for, and the amount that is unpaid provided by carers. Subject to a number of caveats but based on these data and using the most conservative estimates (i.e. the minimum values in the range) analysis shows that at least 288.5 million hours of care were provided by unpaid carers in Wales in 2001. When compared with the most recent data that 11.7 million annual hours were provided by local authorities (including services commissioned and delivered by others), this demonstrates that a hugely significant 96% of annual care hours in Wales are provided by unpaid carers, with the remaining 4% provided by local authorities and independent providers.

RESEARCH FINDINGS

WHAT IS THE FUTURE VISION FOR CARE AT HOME AND ITS WORKFORCE?

THE FUTURE OF FUNDING

One of the most significant issues facing the sector is around the future payment for social care. There have now been Green Paper consultations in both England and Wales on paying for social care which both set out the case for change. Both papers offered specific proposals for how social care might be afforded into the future. Whilst they did not specify the particular impact on care at home, they shared a common basis in recognising five possible models for funding: Pay for yourself; Partnership; Insurance; Comprehensive; and Tax-funded. The Welsh White Paper has yet to be published. What are the implications for care at home of these debates about funding? This is almost impossible to determine at this juncture given that the consultation has only just closed, but there are indications of the direction of travel in Wales from other sources. One aspect of this is a new regime for charging which will ensure that local authorities across Wales adopt a more consistent approach to charging service users for non-residential social care services. The ‘Social Care Charges (Wales) Measure’ will limit charges for social care in Wales to £50 per week. This new charging regime - scheduled to be introduced from April 2011 - will clearly have significant and far reaching consequences for the commissioning and delivery of care at home services.

VISIONING THE FUTURE CARE AT HOME WORKFORCE

In order to make sense of these financial and other challenges and understand the vision for the care at home workforce in Wales in more detail, the research team organised a Workforce Visioning Event (held in April 2009) at which nearly 50 stakeholders participated in discussions. During the course of deliberations it became

clear that key themes were emerging, all of which had workforce implications:

1. **Support care at home workers to provide the best care possible**, and make dynamic efforts to ensure the long-term sustainability of the workforce;

2. **Ensure financial viability of care**, by moving towards thinking about where greatest value may be gained;

3. **Promote independence and choice for service users**, by placing them at the centre of all decisions about their care;

4. **Enable continuity of provision across professional boundaries**;

5. **Recognise and value the crucial importance of those in families and communities supporting those in need**; and

6. **Move towards an outcomes-focused and personalised service for all care provided**, regardless of circumstance.

It was decided that the first two themes were of such central importance that they had to feature as part of all the other discussions rather than being isolated. In addition, two key dimensions underpinning the future for care at home were identified as being especially important: commissioning, and regulation and registration.

**Commissioning**

In terms of commissioning the Low Pay Commission\(^6\) recognises that ‘the commissioning policies of local authorities and the NHS should reflect the actual costs of care, including the National Minimum Wage’. This was discussed at length during the course of the study - the principal issue being that provider agencies across all sectors are either enabled or constrained by commissioning processes. Whilst there is good practice in some places, there are areas in Wales where the relationship between commissioners and providers is such that there are real challenges in being able to deliver uniformly high quality services to citizens. In response to these and a range of other challenges, in its consultation on the ‘Fulfilled Lives, Supportive Communities: Commissioning Framework and Guidance’\(^7\) the Welsh Assembly Government (Assembly Government) proposed thirteen standards against which future commissioning in Wales should be judged. It remains to be seen to what extent these will resolve some of the issues identified above. Of crucial importance in ensuring these standards are delivered will be the role of the local Director of Social Services\(^8\) and in particular the requirement for local authorities to engage and discuss plans with providers.

**Regulation and registration**

In addition to the regulation of agencies, regulation and registration of the care at home workforce was also discussed at some considerable length. There are both costs and benefits of workforce regulation and registration, and it is important to contextualise the discussion here in the light of these. The Better Regulation Task Force, then the Better Regulation Commission, and subsequently the Risk and Regulation Advisory Council have advocated that decisions about regulation need to be based on five principles: proportionality; accountability; consistency; transparency; and targeting. In addition each of these principles is tested against a number of questions: is it necessary, affordable, fair, effective, simple to understand, easy to administer, and commanding of public support?

The Care Council has plans to register all managers of domiciliary care services by 1st July 2012, but has not set any of the terms and conditions to date. The Care Standards Act 2000 requires that the Care Council ‘make provision for the registration, regulation and training of social care workers’ but as of yet in terms of the broader care at home workforce no dates have been set.

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\(^8\) These were recently described in the recent document: Welsh Assembly Government (2009) *Statutory Guidance on the Role and Accountabilities of the Director of Social Services* Cardiff
KEY IMPLICATIONS FOR
THE WORKFORCE

Key findings under the four themes -
Independence and choice for service users;
Provision across boundaries; the Role of families
and communities; and Outcome-focused working -
are presented below. In the Final Report the views
of service users, carers, care workers, supervisors,
managers and other stakeholders, coupled with
notable practice examples are used to support the
analysis. It is understandably not possible to
replicate that approach here - the summaries
below are meant to indicate the kinds of issues
covered in order to provide an evidence base for
the Recommendations.

Independence and choice for
service users

There are a number of barriers related directly to the
workforce which inhibit the independence of service
users and interfere with the way in which care
should be provided: lack of choice over care provider;
service users and carers who may not be listened to
by care workers, supervisors and assessors; lack of
flexibility in care packages; poor signposting; and a
range of other language and cultural barriers.

Despite the barriers noted above there are a number
of features of care at home services that enable
service users and carers to have greater
independence and choice. These include a broad
number of policies and initiatives collected under the
banner of ‘personalisation’ - whether defined in
terms of self-directed support, direct payments, or
more generally having more control over care and
support. Specifically the opportunity to employ
personal assistants (PAs) through a direct payment or
self-financed care can afford much greater
independence. That said there are for many service
users significant burdens associated with increased personalisation have been
effectively dealt with. Given that in Wales
personalisation is in its relative infancy, there are real
opportunities to learn from the experiences
of others in order to avoid common problems
and challenges.

Provision across boundaries

The partnership, co-ordination, co-operation and
integration of social care with those it ‘interfaces’
with regularly - mainly health and housing - is
central to the effective provision of services across
boundaries. At the heart of this is the workforce.
There are exciting possibilities for care workers (and
social care staff more broadly) to develop their skills
in these areas. However despite the recent
reorganisation of healthcare organisations in Wales
and the drive towards providing more services in
community settings there are still stubborn
challenges to effective integrated working. Many
of these challenges were self evident during the
course of the research and are broadly summarised
as a lack of joined-up working. They include issues
like medications recording, compliance and
administration; sharing a common language and
understandings of contested terms; establishing
clear information and data collection and sharing
protocols; and obtaining better local ‘intelligence’
about key services so that those working at the
front line are more effectively able to signpost
service users across sectoral boundaries. Reasons
for these problems are long-standing and rooted in
professional practice and cultures, and are
exacerbated at the cross-over between the public
sector and the independent sector.

Liaison between services is clearly important if
service users are to get seamless provision across
boundaries, a key element of which is having an
integrated information system like that instigated
in the Torbay Care Trust. Other potential solutions
are provided by developments in new types
of workers like cross-boundary (or generic) support
workers, and in allowing roles to naturally evolve
across boundaries so that low-level assessments
(like for some community equipment) do not
require the intervention of specialists such as
occupational therapists.

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10 Jones C et al (2009) Setting the Direction Primary and Community Service Strategic Delivery Programme

Role of families and communities

Families and communities provide more than 95% of the care at home across Wales and without this input there would be fundamental challenges to the formal system of provision. Despite this vital contribution, evidence suggests that some service users often wish certain very personal tasks to be undertaken by ‘others’ instead of those that are closest to. As such there are a range of issues which arise at the cross-over between the formal (paid care worker) and informal (unpaid carer) workforce, as well as around the boundaries of what care packages offer and what they do not, which arose through the study. The number and range of issues identified signal a considerable need for solutions to be identified: lack of clear demarcation of the boundaries between what can be provided and what cannot; relationships with families, and the criticism of care workers which can follow; and dealing with more substantial conflicts. There may well be a role for Microboards - small groups of committed family and friends who come together with a service user to address the person’s support needs in an empowered way and decide on how best to spend budgets - in resolving some of these issues.

Whilst the ‘Carers’ Strategy for Wales: Action Plan 2007’ has refocused previous Carers’ Strategies and reset the strategic direction for the Assembly Government there is still a gap between policy and practice in relation to carers. Future direction in Wales will also be shaped by the Carers Legislative Competence Order and its respective measures. This will be instrumental in setting the agenda for dealing with issues at the interface between the provision of formal and informal care.

Outcome-focused working

‘Outcomes’ refer to the impacts or end results of services on a person’s life and outcomes-focused services are therefore those that aim to achieve the goals, aspirations or priorities of individual service users. There is a high degree of consistency between different studies in the outcomes that are valued by older people; these relate closely to quality of life and ‘senses’ of security, belonging, continuity, purpose, achievement, and significance. There are an increasing number of examples of outcomes-focused working in Wales, but there are clear workforce implications which arose when engaging with service users and carers on the topic of outcomes. Those that related to service provision in particular were around reliability, flexibility, continuity of care, maintaining independence, and care worker skills. Outcomes for service users will vary greatly. Outcomes for the workforce delivering that care will also vary greatly. There will still be tasks required to deliver people’s outcomes. Understanding the implications for the workforce (in training, cultural change, and relationship between task and outcome) in making the transition between task and outcome is therefore fundamental here.


13 For more information see http://www.microboard.org and http://www.velamicroboardsni.org.uk

IMPLICATIONS FOR THE FUTURE

WHAT DO WE NEED TO DO TO MOVE THE CURRENT WORKFORCE TOWARDS THE VISION?

Having analysed the current state of the workforce and the vision for the future, the study concluded by concentrating on how best to equip the care at home workforce for the challenges to come. Many of those challenges are already with us, and a credible strategy needs to address them. But the future will also create new challenges, and may cast existing ones in a different light. Our Recommendations therefore need to be ‘future proofed’ as far as possible. One major change should be singled out for specific attention again here - the likely changes to social care funding. As noted the ‘Paying for Care’ consultation outlined five options, and assessed their capacity to meet the core principles of social care provision: universality; affordability, sustainability and fairness; clarity; and assistance in providing independence. There is much uncertainty about which of the options will be adopted but as far care at home workers are concerned, each will have the same broad consequences since each is designed to meet the same core principles set out above. Where they differ is in the extent of their impact across the criteria below taken from the Green Paper:

- More workers, as the emphasis shifts from institutional care;
- More clients, as the demographics change and more live longer at home;
- Greater equity of provision, albeit with different sources of funding;
- More control vested in the client, as each option seeks to ‘personalise’; and
- Greater clarity for clients about how to get what they need.

The key variable, as far as the care at home workforce is concerned, is the extent to which each option requires the client to negotiate and manage their own provision. Each of the Recommendations which follows, therefore, is relevant to each of the proposed funding options.

RECOMMENDATIONS

We make five key recommendations which are underpinned by 22 specific ‘sub-recommendations’. As far as possible we have indicated the relevant organisations and partners that would need to be involved to make each of these a reality. Importantly whilst each of the Key Recommendations has a potential and clear benefit, there are costs attached to each of these changes. In places these costs and benefits will be well known but in others they will be less easy to discern. Cutting across all of this is the need to ‘carer-proof’ these recommendations as advocated by the Carers’ Strategy to assess their impact on carers and to make adjustments where necessary given the significance of the unpaid workforce in securing the independence of so many vulnerable people at home. In the same way, each of the Recommendations are directly relevant to providers and their workforce. Rather than cite them each time in the ‘Actions’ it should be understood that their involvement is central - where they are referenced they are especially important to the success of the issue at hand.

Furthermore it is essential that providers and care workers are engaged fully as this agenda evolves and decisions are taken about the changes discussed here. There is a need to establish and consolidate a comprehensive network/forum for regulated domiciliary care agencies in Wales, and their workforces, to assist in taking forward the vital work streams outlined in the recommendations. This project has begun this process of engagement and there is a role for the Care Council to continue this relationship, and think through the implications for instigating a professional body to support the workforce in Wales.

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RECOGNISE THE VALUE OF THE CARE AT HOME WORKFORCE

This recommendation acknowledges the way in which care at home workers, in all sectors, have responded to the evolving challenges posed in meeting the support needs of vulnerable people. The response of such workers has often required the application of new knowledge and skills. The extent of that knowledge and the nature of those skills often go unrecognised and this is reflected in the low status that is often ascribed to ‘care jobs’. Much of these changes have been made for little additional reward. Care at home services are perennially short of resources and need improved funding - however as an era of cuts begins, there are real fears that what is already stretched will need to be stretched further.

1.1 It is recommended that the terms and conditions of care at home workers are reviewed to ensure that they are being appropriately remunerated for the job they do.

There are a number of reasons as to why front line care workers will receive different terms and conditions for the jobs they do - qualifications obtained, years of service, who their employer is. In view of the changing nature of the work and the challenges that face them, there is an opportunity to recognise the key role that is being played by these care workers through reviewing their terms and conditions. This process would potentially enhance their status as professionals in knowing that their role is valued. We acknowledge that reviews of terms and conditions by individual employers may lead to a greater number of pay rates for ostensibly the same job which could actively undermine the principle of ‘one sector, one workforce’ and lead to an undesirable increased turnover of staff between employers. This is to be avoided but, that said, we recognise that the local authority job evaluation process is one over which in-house employers have little control.

[Action - Assembly Government, Care Council, local authorities, service providers]

1.2 It is recommended that strenuous efforts are made in securing new recruits and retaining the employment of those already working in the sector.

In a society where increasing numbers of vulnerable people are supported at home, it is essential that endeavours are made to ensure their inclusion where appropriate, in family, community and economic life. If the care at home workforce is devalued, then so is the status of those for whom care and support is given. Adoption of a Red, Amber, Green system based on experience and complexity of cases could help retain staff. Should there be sufficient resource available, and should the outcome from ‘Paying for Care’ justify it, consideration should be given to a campaign that bears testimony to the importance of the role of care and support workers (including Personal Assistants, or PAs), which signals the career opportunities that can be harnessed, and helps recruit to the care at home workforce. Further it is recommended that the proposed Standard 12 of the new Commissioning Guidance must be used to ensure this is delivered.

[Action - Assembly Government, Care Council, local authorities, service providers]

This system reduces staff turnover by grading new workers as Red, Amber or Green on their experience, qualifications and capabilities and allows them to be appropriately matched with service users on the basis of case complexity - for more information see Box 7 (p.50) of the full Final Report.
1.3 Following from the above, it is recommended that the registration of care at home workers (including PAs) is achieved as soon as is practical.

Whilst the Care Standards Act 2000 requires that the Care Council ‘make provision for the registration, regulation and training of social care workers’ as of yet no dates have been set for the care at home workforce (except managers of domiciliary care services who will be registered by July 2012). If implemented it is anticipated that registration could offer:

- different registration ‘classes’ according to the responsibilities of, and roles carried out by, care at home staff (e.g. PA, care/support worker, direct front line manager or service manager);
- role profiles for each registration class, indicating the mandatory and optional National Occupational Standards (NOS) and the recommended qualifications for each class;
- the facility for registered practitioners to record the NOS they are competent in and the date their competence was accredited;
- a requirement for registered practitioners to comply with Codes of Practice that are relevant to their roles (whether relating to social care, health, housing or other support);
- a requirement for registered practitioners to fulfil conditions under a framework for their continuing professional development. Amongst other things this should include:
  - regular professional supervision;
  - a personal development plan reviewed at least once per year; and
  - a career progression ladder showing the links between the role profiles in each class;
- recognition of the contribution made by care at home staff to both the social and health components of personal well-being; and links to local and national training provision leading to accreditation of competence in the various NOS or Qualifications and Credit Framework (QCF) units which might take the form of a tracked training and development portfolio.

The nature of registration and the detail of its implementation - like the potential charge, the relationship between registration and disciplinary action, and the potential role for a professional body for care at home workers, for example - have yet to be worked through and should be subject to a detailed further study. That said, whatever future decisions are taken about regulation and registration it would be expedient to consider proposals against the five principles (of proportionality, accountability, consistency, transparency and targeting) and test questions established by the Better Regulation Task Force, Better Regulation Commission and Risk and Regulation Advisory Council to ensure full account of the costs and benefits are considered. It is also important to see this in the context of the evolving regulatory landscape in Wales, and to avoid duplication with the implementation of the Vetting and Barring Scheme.

[Action - Care Council, Assembly Government, service providers]

1.4 Acknowledging that registration will take a significant amount of time to achieve, it is recommended in the meantime that a National Minimum Dataset for care at home in Wales is developed as quickly as possible.

The best estimate available acknowledges that there are circa 15,500 care at home workers in Wales - 6,857 employed by local authorities and an estimated 8,727 in the independent and third sectors. There are real threats to care at home in Wales if it is not possible to more accurately determine the current level of the workforce, its qualifications, skills, demographic profile and other characteristics. This situation is especially grave in the independent (private and third) sector, and for a potentially growing number of PAs. A precondition of registration is that we will know more about the workforce, but given the immediate uncertainties about the future remedial action must be taken in lieu of registration in order to provide an accurate picture of where we are now, and where we might need to get to in order so that effective planning can be undertaken.

[Action - Assembly Government, CSSIW]
1.5 It is recommended that the funding for training all staff - front line care workers, managers (including supervisors and direct service managers), co-ordinators and commissioners - be reviewed and that action is taken to ensure that workforce skills are augmented and their further development is supported. Given the dearth of information about the levels of training of the workforce it is not possible to ascertain the degree of training across the sector. One of the outcomes of this is to point to the adequacy or otherwise of training and the funding arrangements underpinning it, including that for PAs. There are potential financial implications of understanding this position more clearly - a review may well identify a need for more training and not be cost neutral. The importance of a secure, protected fund for training has been recognised in England where the Sector Skills Council has a budget - this should be replicated here.

[Action - Assembly Government, Care Council, local authorities, service providers]

1.6 Subject to the outcome of the current review of In Safe Hands, and linked to Recommendation 1.3, it is recommended that efforts are redoubled to ensure that the workforce is properly trained (and updated) in this important area.

Care at home workers have important roles to play in the protection of vulnerable adults. There is considerable concern that the abuse of vulnerable adults is under-recognised and -reported, and care at home workers are a vital source of intelligence in relation to potential abuse. All workers should therefore continue to be trained in the nature of such abuse, how to recognise it, and what to do if they have suspicions that abuse may be taking place. Particular attention should be given to PAs in this regard, since their relative isolation within the protection structures may make the reporting of abuse more difficult for them.

[Action - Assembly Government, commissioners, service providers]

1.7 It is recommended that Assembly Government closely monitors the impact of the new Commissioning Guidance on the delivery of care at home services in Wales and on achieving a quality, sustainable workforce, enforcing the new standards wherever necessary.

In 2009 the Low Pay Commission argued that the commissioning policies of local authorities should reflect the actual costs of care, including the National Minimum Wage. The standards of the new Commissioning Guidance in Wales provide an opportunity to realise this agenda if they are fully implemented - monitoring and enforcement are key aspects of any such implementation.

[Action - Assembly Government, CSSIW, commissioners]
This recommendation responds to the clear need to move from what may sometimes be regarded as overly prescribed and narrow task driven roles for care and support workers to ones that are more choice and opportunity driven. This reflects the need for more flexible approaches involving partnerships that can deliver on well-being (with both its social and health components) as well as supporting ‘activities of daily living’.

2.1 It is recommended that an enhanced role for care/support workers and their direct managers/supervisors in assessment, planning, signposting, co-ordination and review of service users’ and their carers’ and families’ needs is promoted.

Given the vulnerability and varying needs of people supported by the care at home workforce, it is unsurprising that much is done that does not closely ‘fit’ with prescribed packages of care. Some care workers (those working in an outcome-focused way, or those providing assessments of need for example) are remitted to be flexible - and are involved with the user in reviewing needs, planning support and care, motivating users, monitoring (with users and carers) their progress towards agreed outcomes. They offer, in their approach, a striking counterpoint to others who are permitted only to perform key tasks. The discretion (and, therefore, responsibility) afforded to such staff can be regarded as linked to an increased value placed on the role of front line care workers and managers. Wherever necessary the role enhancement should be developed in partnership across health and social care to achieve the common goals of well being and independent living.

[Action - Assembly Government, commissioners, service providers]

2.2 It is recommended that new NOS are developed describing the new functions in the expanding role of the care at home workforce.

Specifically linked to the above, a new Level 3 NOS should be developed (building on HSC25 Carry out and provide feedback on specific plan of care activities) covering this broader remit. This NOS should be introduced into the care/support worker’s role profile, initially as an option. Further NOS might also be appropriate based on HSC328 (Contribute to assessing the needs and preferences of individuals) and relating to the role of care at home workers in care/support co-ordination. More broadly in a context where greater skills and knowledge are linked with more complex needs of vulnerable people it stands to reason that some care at home staff will wish to specialise in ways that will relate to particular support needs. Examples would include those who support people with vision impairments, learning disabilities and dementia.

[Action - Care Council as part of Skills for Care and Development]

2.3 It is recommended that the role of carers is more actively supported by front line workers and others to enhance the quality of care for service users.

A recommendation recently made to the Care Council in relation to working with older people experiencing dementia\(^{18}\) suggested that involving carers more actively in the care provided is often not straightforward, and issues such as liability, risk assessment, and inflexible structures can get in the way of creative solutions. Further that more needs to be done to enable sharing of personal histories and current care preferences, as well as recording information appropriately. Research from this study would confirm that hypothesis and if implemented, Recommendation 2.1 above would go some way towards achieving this, but here we recognise the breadth of the challenge and the key role of care workers in acting as effective signposts to other services.

[Action - Care Council, key stakeholders including carers, providers]

\(^{18}\) Rowett R et al (2009) Good Practice in Relation to Working with Older People Experiencing Dementia - a report on behalf of the Care Council for Wales, Cardiff

\(^{19}\) Welsh Assembly Government (2009) Rural Health Plan: improving integrated service delivery Cardiff
3 | ADDRESS THE WORKFORCE IMPLICATIONS OF DEVELOPING INTEGRATED SERVICES

This recommendation responds to concerns about the compartmentalisation of care at home within service and professional silos. As recognised in the ‘Rural Health Plan’19, ‘despite the progress made in service integration and joint commissioning, health and social care sectors still have difficulty in understanding each other’s culture, context, culture and financial and governance constraints’. The call for integrated services reflects the need for them not just to be person-focused but to respond to user and carer choices. Integration means the development of frameworks and nurturing of skills that cross divisions between social care, health, housing and others.

3.1 It is recommended that qualification and training schema are developed that will support the development of new types of worker like cross-boundary (generic) support workers and the extension of current care at home roles into areas like re-ablement.

Delivering services in new ways means that appropriate training (as well as service visions) must be in place. The opportunity to work more effectively across service boundaries requires that frameworks for training and skills development must change. Imaginative planning and means of delivery is needed in relation to generic educational courses and qualifications, and training programmes will be needed to develop appropriate skills to meet these needs at all levels.

[Action - Care Council, service providers]

3.2 It is recommended that the regulatory requirements for the new types of worker advocated for care at home are explored as a matter of urgency.

In order to secure both the workforce and those for whom they are caring, discussions need to take place in order to develop an appropriate and accountable regulatory framework for these new roles given their centrality to delivering effective care at home in Wales, both currently and into the future. Negotiations about the implications of these roles with regulatory/ professional bodies representative of those at the vanguard of these developments are now necessary, and are possibly overdue.

[Action - Assembly Government, CSSIW, Care Council, healthcare regulators and professional bodies]

3.3 It is recommended that those leading work across boundaries (whether between health and social care, or within sectors) relieve a number of the persistent pressures experienced by the workforce through the instigation of a series of workstreams.

The principles behind the Memorandum of Understanding ‘Securing Strong Partnerships in Care’20 need to be translated into local, practical action. Key areas for consideration in workstreams designed to secure more integrated partnerships - across and within sectors - include:

- medications (recording, compliance and administration);
- common language and shared understandings of contested terms (relating to things such as re-ablement, rehabilitation, intermediate care, empowerment and choice);
- ensuring all relevant stakeholders meet the requirements of the relevant partnership working NOS;
- establishing clear information/data collection and sharing protocols, building on the Wales Accord for the Sharing of Personal Information21

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20 Welsh Local Government Association, Association of Directors of Social Services Cymru, Care Forum Wales, the Registered Nursing Home Association and the UK Home Care Association (2009) Securing Strong Partnerships in Care WLGA/ADSS

21 See http://www.wales.nhs.uk/sites3/home.cfm?orgid=702 and also Box 8 (p.55) of the full Final Report - a brief summary is included in Appendix 1 of this document.
framework;

- support services that provide ‘that little bit of help’ (befriending, community support, domestic assistance and others) that have benefits for service users, and health and social care systems by preventing escalating needs;
- developing a single health and social care record for use in the home by the individual, carers, care workers and health professionals;
- better local ‘intelligence’ sharing about key services so that those working at the front line are more effectively able to signpost service users across sectoral boundaries.

[Action - Assembly Government, local health boards leaders, local authority leaders]

3.4 It is recommended that partners responsible for developing services within the care at home environment undertake workforce planning across both health and social care settings to maximise the opportunities to develop a more flexible health and social care workforce for the future.

Recent work to develop the new integrated workforce planning process for NHS Wales has pointed strongly to the key interface across health and social care in terms of workforce planning. The Assembly Government sanctioned workstreams which will take this work forward offer an excellent opportunity to discuss with partners ideas for integrating workforce planning procedures.

[Action - Assembly Government, Care Council, NLIAH]

4 | SUPPORT THE WORKFORCE IN DELIVERING OUTCOME- AND PERSON-FOCUSED SERVICES

This recommendation responds to the need to counter the worst effects of task driven approaches where few or limited choices are available for users and carers. It underpins the notion that person-focused outcomes must expand those choices and should relate, in key respects, to user rather than management outcomes.

4.1 It is recommended that the Care Council, working within Skills for Care and Development, should review the NOS, QCF, training and skills for commissioners, service managers and front line workers to ensure they effectively underpin outcome-focused working.

This is to ensure they are fit-for-purpose given the challenge of the move towards supporting outcomes-focused working and embracing any new or extended areas of required competence. Some changes may be required to existing NOS, and/or new NOS may need to be developed covering the function: Support individuals to work towards targets for improving their health and wellbeing. Complementary actions that are addressed towards the needs of care at home workers will help commissioners and service managers to develop their competencies in relation to new service approaches and frameworks.

[Action - Care Council]
4.2 It is recommended that decisions about care packages are always taken in a collaborative way such that service users, carers and the workforce are as fully engaged in these decisions as possible.

Outcome- and person-focused services require much closer attention to be given to the needs of both users and carers, as well as fundamentally changing the nature of the relationship. If the new model of working is to be truly co-productive, with benefits for service users and care workers, a step-change is needed in the partnership between those commissioning, those assessing, those providing and those receiving care. One example of mutual benefit to all is that working to outcomes typically means longer visits. In turn this means less travel time for workers between visits, which has a benefit for the provider as well as a potential benefit for those commissioning services. [Action - Assembly Government, local authorities, service providers]

4.3 It is recommended that the workforce uses a standardised set of processes and accompanying documentation in assessing, reviewing and delivering outcome-focused services.

Whilst there are a number of piecemeal attempts to develop processes and supporting documentation, currently there is no single system for use in Wales. Producing assessment processes, care plans, daily records and review documentation and thereby establishing common process for outcome-focused working for Wales would remove any number of potential barriers. The driver for agreeing a single set of processes and documents would be to get the highest consistency and quality of assessment and reporting rather than every local authority and/or provider having its own systems. This would improve care, save administration and cost, and establish a consistency of approach across Wales. [Action - Assembly Government, Care Council]

5 | EXPLORE THE CONSEQUENCES FOR THE WORKFORCE OF NEW SERVICE OPTIONS AROUND SELF-DIRECTED SUPPORT

This recommendation acknowledges that as the expectations of users and carers change, new service norms and practices will be established. These norms can provide challenges for some providers who have been used to doing things in traditional ways. They directly follow, however, from the agenda associated with personalisation, a key aspect of which relates to self-directed support.

5.1 It is recommended that The Assembly Government and/or Care Council publish accessible guidance to assist the workforce to understand the options available to service users and carers for self-directed care.

The wider development of service frameworks to facilitate self-directed care and support reflects the move towards partnership working between service providers, and a different relationship between service users and all others involved in their care. There may be a key role to be played here for (often voluntary sector) agencies that already have specific and relevant expertise. [Action - Assembly Government, Care Council]

5.2 It is recommended that the Care Council commissions work to identify the competencies needed by service users in order to commission and manage their own care/support.

Those competencies will vary according to the model of service delivery chosen - extending from the user acting as employer to the user being able to make informed choices about allowable services within their own budget for care. The idea of an NOS/QCF unit covering the functions that service users need to be employers, including interviewing skills, should be explored. [Action - Care Council, service providers]
5.3 It is recommended that The Assembly Government gives encouragement and appropriate support for trialling (and evaluating) forms of self-directed support.

The notion of self-directed support should not be seen as just relating to individual users and their carers. Some of the necessary flexibility in care at home that is being called for might be able to be delivered on a local basis. Insofar as aspects of self-directed support may result in increased personal well-being (including better health), more active engagement, and a reduced call on social care, health and housing services, the promotion of services in this way may also respond to some of the concerns and issues being debated in ‘Paying for Care’. Ways of delivering care at home services that should be fully explored include ‘Microboards’ and the development of local co-operatives.22

[Action - Assembly Government]

5.4 It is recommended that the frameworks for training care at home staff, managers and commissioners take account of and support the further development and integration of assistive technologies.

Self-directed support demands that users and carers are able to make informed decisions about care and support services whether they follow traditional or newer patterns of provision. Such decisions may involve harnessing the potential of assistive technologies (including telecare and telehealth) that can reduce the need for care and support being delivered by care workers or carers. One example of this is that given an appropriate set of safeguards, 15-minute ‘check’ calls could be superseded by telecare and telehealth technologies, which could have a series of benefits in releasing capacity within the workforce and realising cost savings for commissioners without negatively impacting hugely on service users for whom 15-minute visits are often unsatisfactory and sub-optimal.

[Action - Assembly Government, Care Council]

5.5 It is recommended that the funding for training PAs is made available in a timely and adequate manner ensuring that there is no shortfall between what is required and what is resourced.

The number of PAs is likely to increase as a consequence of more self-directed support. A significant number of current PAs report that they need to develop certain skills in order to become fully proficient in their job role. Compounding this, service user employers are generally unwilling to fund training for their employees frequently citing the prohibitively high cost. Funding for training does seem to be the main barrier to training provision. Access to training for PAs could be improved if extra funding for training were to be included in direct payments employers’ support packages.

[Action - Assembly Government, commissioners]

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22 For more information see Boxes 5 (p.45) and 14 (p.72) of the full Final Report - a brief summary of these in case studies is included in Appendix 1 of this document.
Appendix

Links with Final Report
There are a number of interesting practice examples, summaries of key research, and innovative experiments in service delivery detailed in the Final Report. Short summaries of these ‘Boxes’ are listed below underneath a heading indicating from which section of the report they are taken. This list is followed by a list of the Appendices which appear in the Final Report - again a summary is provided.

List of ‘Boxes’

Visioning the Future Care at Home Workforce (Section 2.1)

Box 1 | Issues that were to be addressed in the primary research phase
A list of the topics emerging from initial research and discussions which informed the first stage of the project.

Independence and choice for service users (Section 2.2)

Box 2 | Dealing with signposting: a stronger information, advice and advocacy system for older people
Information and guidance from the Joseph Rowntree Foundation on the best way to ensure choice and control for older people is at the heart of the social care system through effective signposting.

Box 3 | How can you use person centred information to drive strategic change and commissioning?
Description of a six stage process developed by the Department of Health to use person centred data - from person centred reviews or support plans - as a vehicle to improve community engagement in needs assessment processes and to enhance commissioning.

Box 4 | Making a support plan
Graphical representation of the process involved in making support plans to help prioritise what is important to service users.

Box 5 | The Collaborative Self-managed Care Project (CSCP): developing mutual models for self-managed care using Direct Payments - Co-Operatives UK, Mutual Advantage and the Department of Health
Data on co-operatives and social enterprises which have been developed to give service users in receipt of their own funds greater control over their care whilst testing and piloting new models of service delivery.

Box 6 | Telecare, telehealth and its role in independence and choice
Some information about the ways in which telecare and telehealth might be developed to meet the challenge of the future in delivering care at home services.

Box 7 | Combating a high turnover of staff and ensuring continuity for service users - the Red, Amber, Green (RAG) system
A scheme instigated by an independent sector provider to reduce high levels of turnover by grading new workers on the basis of their experience, qualifications and capabilities and allowing them to begin their employment with less intensive and complex cases.

Provision Across Boundaries (Section 2.3)

Box 8 | Resolving data sharing problems: the Wales Accord for the Sharing of Personal Information (WASPI)
Information about WASPI which provides a framework for sharing information between service providing organisations in a lawful and intelligent way by establishing requirements and mechanisms for exchanging data.

Box 9 | Principles of working in partnership across health and social care
Twelve principles at the heart of good partnership working identified after research.
Box 10 | Meeting the challenge of medication: the Cardiff Medicines Administration Scheme (CARMAS)
Details of the above scheme which has developed excellent working relationships between social care workers and pharmacists - benefitting both as well as service users.

Box 11 | Making assessments at front line - care packages and community equipment
Three working examples of how front line staff can be more actively involved and develop their role - care package assessments in Essex, equipment assessments in Buckinghamshire and a trusted assessor scheme in Solihull.

Box 12 | Intermediate care and re-ablement - the Canllaw scheme, Carmarthenshire
Information about the scheme which has brought together statutory partners across the county to provide an intermediate care service which has received a positive evaluation.

Role of Families and Communities (Section 2.4)
Box 13 | Carer involvement in care worker training - Wrexham
Data on the Wrexham Council scheme to give carers a direct input into the training of workers to ensure their voice is heard and taken into account when care is delivered.

Box 14 | Vela Microboards in Northern Ireland
Details of how Microboards - a small group of committed family and friends who come together with a service user to address the person’s support needs in an empowered way - are working.

Outcome-Focused Working (Section 2.5)
Box 15 | Outcome-focused working in Wales - strategic and operational
Two examples - from Torfaen (on commissioning) and Newport (on service delivery) - are discussed giving information about how outcomes-focused working in Wales is developing.

Box 16 | Providing community services - not care but support
Two working examples of how broader community services are interfacing with care at home services to support people to remain at home for as long as possible - ‘Village Agents’ in Gloucestershire, and the ‘Food Train’ in Dumfries and Galloway.
List of Appendices

Appendix 1 | Original Terms of Reference
Details of the original specification for the project including the stated aims and objectives at the outset.

Appendix 2 | Outline Methodology
A description of the methods employed during the course of the project in order to collect the evidence as presented.

Appendix 3 | Summary of Main Community Care Statutes
Data from the Law Commission about the legal position affecting social care in the UK.

Appendix 4 | Key Parameters
Information on four parameters which describe the shifts underpinning care at home: functional ability, safety, person-focused services, and ablement.

Appendix 5 | Workforce Data
Tables of data supporting the workforce information gathered and reported upon.

Appendix 6 | Workforce Visioning Event - information from discussions
Feedback from group discussions at the Event held with 50 stakeholders in April 2009.

Appendix 7 | Deliberative Workshops - Summary
Summary of the information and data collected at the four themed deliberative workshops - on Independence and Choice, Provision Across Boundaries, the Role of Families and Communities, and Outcome-Focused working - held monthly from October 2009 to January 2010.

Appendix 8 | Functional Map of Care at Home in Wales
Analysis of the functions needed to commission, plan, and deliver care at home services with links to the relevant National Occupational Standards for those functions.

Appendix 9 | Development of the Generic Worker in Wales
Draft paper looking at initial development of the cross-boundary, or generic, support worker role across different Welsh local authority areas.

Appendix 10 | Analysis of Cross-Boundary (Generic) Support Worker Person Specifications and Job Profiles
An analysis of current person specification and job profiles to determine key features in common between cross-boundary, or generic, support workers and to link these key features to the relevant National Occupational Standards.

Appendix 11 | Cross Reference Between Recommendations and ‘Your View’ Solutions
A link between the Recommendations made in the Final Report (and reported in this Summary Report) and the ‘Your View’ document which collated all the views heard during the course of the project and was sent out to the 240 participants for validation and comment.

Appendix 12 | Implications of the Recommendations for the Competence of the Workforce and the National Occupational Standards
Information about the implications of the Recommendations made for the National Occupational Standards should those Recommendations be implemented.

Appendix 13 | References