



## Welsh Government White Paper: Rebalancing care and support – a consultation on improving the social care arrangements and strengthening partnership working to better support people’s well-being

### A response from WCVA and informed by the contribution of voluntary sector organisations operating in Wales

**Wales Council for Voluntary Action (WCVA)** is the national membership organisation for the voluntary sector<sup>1</sup> in Wales. WCVA's vision is for a future where the voluntary sector and volunteering thrives across Wales, improving wellbeing for all. Our mission is to be a catalyst for positive change by connecting, enabling and influencing.

WCVA works with the Third Sector Partnership Council (TSPC) networks, representing 26 categories of third sector interest, the 19 county voluntary councils (CVCs) through Third Sector Support Wales and other development agencies and networks (e.g. the Health, Social Care and Well-being Planning Group), to provide a support structure for the sector in Wales.

The voluntary sector in Wales comprises over eight per cent of the paid Welsh workforce. This equates to approximately 100,000 employees with 48,500 of these who work in health and social care which make a considerable contribution of providing care and support services close to home.

## 1. INTRODUCTION

WCVA welcomes the opportunity to respond to the consultation on the White Paper, and present the feedback and offer a contribution of ideas from a broad range of voluntary and community sector organisations. Two WCVA online consultation events took place on 2 and 12 March 2021. The discussions in each of the consultation sessions were summarised by Carys Mair Thomas, freelance consultant which have informed this comprehensive WCVA sector wide consultation response to the proposals outlined in the White Paper. Ahead of

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<sup>1</sup> The voluntary sector referenced as ‘the sector’ throughout the paper unless otherwise stated.

the consultation sessions, WCVA asked participants to respond to three pre-event questions:

1. *What is your overall impression of what is proposed in the White Paper? What might it mean for your organisation? What will it mean for those providing care and support services in the community?*
2. *What are the key positives outlined?*
3. *What do you consider to be the barriers and challenges to what is proposed within the Paper?*

These comments have been included in this response in Section 2 setting out the overarching feedback. Section 3 sets out the response to the consultation questions.

Given the number and complexity of created consultation questions, online polls were created in order to speed up the process, the results of which are listed as an Appendix (1), with individual results also included under each question where a poll was conducted. Appendix 2 sets out the key contributors to this response.

## **2. OVERARCHING FEEDBACK**

### **2.1 Being citizen-focused**

Foremost to any proposed change is the importance of citizens; those who benefit or are likely to benefit from care and support services whoever is providing them. This means that there need to be robust mechanisms in place for them to have a clear say as to how they are supported, and that they are involved in the design of care and support services from the outset.

White Papers tend to focus on the macro and, in this context, centres on the establishment of a national office and national framework, but also on the meso level, from a structural perspective, in relation to the future functions of the Regional Partnership Boards (RPBs). It is not sufficiently community focused. A significant amount of prevention and early intervention work happens which needs sustaining to take the pressure off the front door of social services and the NHS.

Overwhelmingly, the consultation questions were felt to be insufficiently citizen-focused and somewhat process driven, glossing over issues found at the micro level, grassroots and out in the community. A consultation with closed questions means it has not used co-productive principles and questions arose around the engagement undertaken by Government to draw up the White Paper proposals. As a result, it is felt that the consultation process will struggle to uncover:

- Where fragility already exists in the system and not just in certain services,
- what needs to happen to build firmer foundations,
- how to avoid cracks appearing in the new structures, and
- how to help people build and witness securer foundations for a system from they will benefit

***“It is difficult - even impossible - to see how individuals are going to be able to exercise voice, choice and control in what looks like a hierarchical bureaucratic nightmare scenario.”***

**Consultation Participant**

## **2.2 Embedding co-productive practices**

There is still a long way to go to embed and invest in co-productive cross-sector practices, both in terms of co-producing commissioning and commissioning for co-production. Despite it regularly being cited at grassroots level as crucial to good practice, co-production is only briefly mentioned in the White Paper. When co-production is meaningfully embraced, we are able to remove systems that do not work, as we have listened and responded to what really matters to people. There needs to be a formal commitment to co-produce far beyond the Social Services and Well-being (Wales) Act 2014 (SSWBA), building on the trusting relationships that have already emerged as a consequence of COVID-19. Citizen Panels have a role to play in identifying areas for change, but such Panels need to be reviewed to understand their role and current effectiveness.

## **2.3 Social Value and Social Value Forums**

As mentioned in the White Paper, Social Value Forums could become the body that is able to try things out and make recommendations as to what kinds of social value models can deliver sustainable care and support services in local communities. It is crucial that Social Value Forums interact with the RPBs and a National Office, but the question is whether this will result in too many structural layers being constructed, which will ultimately lead to too much bureaucracy. Furthermore, there needs to be more clarity as to how social value is measured, that the TOMS framework does needs further work from a social care perspective and that organisations need training on the use of TOMS if they are asked to use it.

## **2.4 Using existing legislation and policies**

The White Paper sets a very positive vision and the SSWBA provides a good basis for the new approach outlined, as it embraces the core principles that have been advocated overtime, such as voice, control, and the need to work together with people in designing and delivering services. There has been and continues to be, consensus that it is ground-breaking legislation. The duties in Section 16 are key to its successful roll-out in terms of developing alternative care and support models. It would be a welcomed approach to map the key parts of the Paper against the core principles of the Act to ensure that what is

proposed is going in the right direction. Equally, the premise of A Healthier Wales - to consider a radical route to deliver change mechanisms in social care - should be observed to make sure that the direction of travel works for the benefit of all, especially service users and carers.

## **2.5 Focusing on quality and social value**

There is a real appetite to move away from a price-driven culture in the social care market and towards a more authentic focus on quality and social value through service improvement. It is important to change the emphasis of the White Paper towards community-based, local, and place-based social care services. There is agreement to move away from the current monopoly in play and create circumstances where organisations know their communities and are given a level playing field to provide bespoke, tailored services through social value commissioning processes.

## **2.6 Existing concerns related to RPBs need to be resolved**

The voluntary sector's concerns relating to the role and function of Regional Partnership Boards (RPBs) are well-documented. There is concern that making them legal entities will not lead to any appreciable difference with regard to equity 'around the table' or as to how care and support services are commissioned and whether this can be achieved regionally. Though there is an appreciation that the devil is in the detail, more information is needed on the role of the national office, and the new functions of RPBs (such as employing staff, for example) in creating cross-sector partnerships, while simultaneously listening to citizens' voices in changing, for the better, service delivery and practice.

## **2.7 Care and support plans should be the starting point**

Care and support plans should form the basis of a national framework and not vice versa and the means to aggregate those plans to identify the types and level of care and support services, especially on a local footprint to provide holistic service delivery. This is a potential red flag for the voluntary sector, as there is a real danger the framework will be based less on need and more on who will deliver commissioned services. leading to them not being co-produced with citizens (service users and carers).

From an individual but also from a prevention and intervention perspective **Social Prescribing** should be an early offer to avoid escalation and crisis. The various models of practice exist but all with a focus on connecting people to non-medical interventions based out in the community. However, Social Prescribing only works on the basis that there are voluntary sector organisations to signpost people to. Volunteers are central to the success of ensuring that Social Prescribing becomes a sustainable alternative or the go-to from the outset to avoid people going through the front door of Social Services and Primary Care.

## 2.8 Welcoming a simplified system of care

Overall, simplification is welcomed, as it will allow us to unpick complexities of current social care provision and return to the fundamentals of care provision and make better use of collective resources. However, that can only work on the basis that key community and voluntary sector care and support services are sustainably resourced as part of the collective.

## 2.9 Securing meaningful outcomes

It is important that the new system is able to measure meaningful outcomes that are both quantitative and qualitative. This will require ongoing data collection and analysis, which will be particularly crucial within a five-year cycle, as it will allow for prompt action in response to the changing needs of communities. Question 8 is a good starting point for this conversation following the end of the consultation period as the data will play a pivotal role in ensuring that needs and services are proportionally matched.

## 2.10 Importance of the voluntary sector

The voluntary sector wants to play an active role in the next steps nationally and regionally and is open to discussions on collective action for change.

There are some concerns, due to the complexities of the content of the White Paper and the multi-faceted questions posed that there needs to be more discussion, more information and time to ask further questions and understand what the proposal means for citizens and stakeholders. This is how the voluntary sector can help shape solutions and modalities, but it is not 'easy' for the public to input into this consultation. One suggestion was that it should perhaps have been 'proof read' by a citizen panel to have made the consultation more accessible.

## 3. CONSULTATION QUESTIONS

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

Our consultation polling for this question found that 91% agreed that complexity in the social care sector inhibits service improvement, with only 7% disagreeing. For example, one person argued that *'person-centred commissioning is enlightened at a local level'* and felt proposals for stronger regional direction and a national framework would impact negatively on this. Overall, however, it was felt that complexity does currently exist in the system as it stands.

Overall, it is felt there are currently too many departments and too little cooperation. There needs to be a lot less bureaucracy, and there is agreement that the social care sector should be simplified rather than made more complicated.

The current eligibility criteria for care is open to interpretation, which results in a postcode lottery across Wales for access to services. This is also the case in relation to quality of service, and consistency in price.

***“If people working in the sector find it hard to understand (the system), then the general public will never be able to navigate their way through the different tiers.”***

**Consultation Participant**

For example, in relation to price and Direct Payments (DPs), there appears to be an arbitrary rate over the hourly rate of DPs adopted by local authorities (LAs). This means that, where services are not available or are more expensive than the rate provided. People in need are either left with no service at all or are shoehorned into purchasing a service that does not meet their assessment needs, resulting in a lack of voice, choice and control. Public perception was also raised as an issue, with one person suggesting that the voluntary sector is perceived as less professional. This can offer another layer of complication. However, a mitigating factor is that the COVID-19 crisis has raised the profile of the voluntary sector and generated a greater understanding of the role of the sector in supporting local communities of need.

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

Our consultation polling for this question found that 74% agreed that commissioning practices are disproportionately focussed on procurement. It should be noted that 21% of consultation participants, who engaged with the poll, struggled to answer the question.

There are some limited examples of good, co-produced, local commissioning arrangements in place in Wales, but it was still felt that the current focus is on cost and obtaining the cheapest service available. This results in people having to fit into very specific boxes to get the support they need, which creates ‘a reductive system’, resulting in people, for example, with Autism or people with other conditions, disabilities, and mental health conditions being given inadequate treatment.

People want to see their involvement in the co-production of their services, included in the way the system measures ‘value’ and move away from problematic practices. For example, the status quo for older adults with high and complex needs, at the moment, is that they will likely go into a care home rather than have care and support at home. But could this not

be an opportunity for there to be fewer institutional settings and higher-level care and support provided in service users' own homes?

Participants felt that with the appropriate support in place, individuals and their families could hold their own budgets and decide for themselves how best to achieve agreed outcomes through Direct Payments or an individual service fund. At the moment, it is felt that service providers dictate the services available, which results in a 'missing middle' and people only looking for support in extreme crises.

***“Will we, at some point, actually get to self-directed care, where people are able to buy support for themselves or as a collective of service users?”***

**Consultation Participant**

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

The current challenges facing RPBs are clear. These have been raised previously by CVCs and other WCVA members and undermine Welsh Government's 'holistic vision':

- Each RPB is structured differently in terms of feeding into the overall board.
- Citizen and carer reps struggle to have any impact on 'decisions', with their voices 'diluted' because there are insufficient numbers at Board level and RPBs fundamentally do not understand nor value co-production.
- Stronger carer and citizen voices are needed in feeder groups, as this is where much of the 'decision-making, ideas and co-production' is undertaken.
- Citizen representatives (many of whom are volunteers) need to be given equal status and remunerated like their Board counterparts, who are paid to navigate the system, in order to recognise their expertise and contribution towards service delivery and stop them from feeling as though they are 'at the tail-end, fighting for their place at the table'. This need to be fully considered if RPBs become legal entities.
- RPBs struggle with transparency, and are often 'cumbersome and ineffective', with agendas 'pre-set and rubberstamped'. Representatives are not fully aware of what they've agreed to, often because they 'get 'a wad of papers' at short notice'. This needs to change.
- When RPBs decisions are challenged, they are 'not often met with a mature reflective response - people can be pretty thin-skinned'.
- RPBs need to be representative, fully accountable, scrutinised and all meetings made open to the public. This will ensure proper auditing, challenge and scrutiny

***“External partners are really outnumbered at RPB and the engine rooms underneath, where most of the decisions are made.”***

**Consultation Participant**

(Currently participants struggle to understand the reporting and accountability line for RPBs).

Most consultation participants believe the design and structure of RPBs are only one part of the problem, with many pointing to the *‘culture and understanding, found in RPBs’* as being *‘a bigger barrier’* for RPBs to deliver on their responsibilities. A major concern lies in insufficient collaboration and ineffective co-production practices, with one participant pointing to one RPB as feeling *‘very remote’*.

There are also concerns that local authorities and health boards are failing to fully embrace co-design and co-production principles, and without a strategic shift in this regard, changing RPBs would make very little difference to outcomes. For one consultation participant, the ICF budget appears to be controlled by the Health Board.

One participant suggested that all those currently involved at RPB level should be required to do more relationship building and more joint training and this has worked well when and where this has happened. It is as much about political will as it is about design and structure if we are to re-shape future services for the better.

Future concerns relate to the proposals limiting the way RPBs are constituted, leading to limited membership and less responsiveness to what people want and need from social care services.

***“Let us not become a small country with a lot of unnecessary infrastructure at a regional level - why not just use national, local and community levels?”***

**Consultation Participant**

One person pointed to widespread research that has found multi-agency working to be a major obstacle in effective social care services. Others point to how local authority and health budgets are already being squeezed, and additional layers would inevitably lead to an additional drain on funding which needs to be avoided.

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

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

Our consultation participants found this to be a *‘huge question’* with multiple components and queried whether its inclusion was appropriate given its complexity, and if this were something that service users and unpaid carers could engage with and give their opinion.

In answering the questions, they felt that it needed unpacking further, putting forward their own basic questions:

- Is commissioning the right approach?



- Is it possible to set a price when the entire process is *meant* to be driven by the citizen?
- Is it possible to measure ‘quality’ and ‘value’ and, if so, by whose definition? Whose criteria will be used?

One participant suggested the Government consider the [‘Meaningful and Measurable’ research study](#) in developing their thinking in relation to these specific proposals. The work of Nick Andrews (Swansea University) is helpful co-productively especially [‘Small is Beautiful’](#) and the importance of storytelling in social care (the lived experience). The work around Building Resilient Communities led by Social Care Wales and Building Communities Trust in partnership with key stakeholders, and the body of work around the community paradigm published by [New Local](#) would also be good to draw upon as well as the work related to Care and Support at Home (Social Care Wales).

Ultimately, participants returned to the need for all proposals to be citizen-focused, creating a system that offers not only consistency in price, but in services; putting an end to the current postcode lottery. As a result, many felt that commissioning needs an entire rethink, especially in the context of market shaping, and reflect the involvement of service users and unpaid carers, as this is where co-production can have a real impact on people’s lived experience. The very definitions of ‘value’ and ‘quality’ need to be co-produced together with families and carers.

All proposals need to have at their core a strong definition of co-productive commissioning, such as the following *‘the process for deciding how to use the total resource available across our community to support people who use services, their families and other carers, in order to improve outcomes in the most efficient, effective, equitable and sustainable way’*. An example already referenced in the White Paper, in relation to the Children’s Commissioning Consortium Cymru (4Cs), also offers a good template in creating an effective, collaborative and relational system.

While *‘prices should not be set arbitrarily’*, there was an overall feeling that using a tool or methodology to set a price market would prove problematic, resulting in it becoming too general or too specific, often leading to unintended consequences and *‘becoming a straitjacket’*. Participants’ reasons for this included:

- The existing system is too remote, with the voices of citizens often unheard and too many levels of bureaucracy in place.
- There are no national quality standards in existence, as found in the education sector, for example.
- Commissioners may simply not have the data to manage a market or effectively assess ‘quality’.

- Concerns that it would not allow for ‘a mutual gain approach’ where communities are able to have influence over how budgets are developed or spent
- Metrics can be blunt instruments and difficulties would arise in formulating a methodology that was flexible enough to consider appropriate local / regional weighting factors (given there are already known examples where hyper local services have proven unviable when matched against same style pricing methodologies. Yet, hyper local activity is more likely to meet local need and contribute to the prevention and early intervention agenda.

It was felt that the development of an enlightened and enabling national framework would be useful and welcomed, particularly if it created cultural and behavioural shifts at all levels of the system, as this would help reduce lines of confusion and arguments around legalities and processes over the five-year cycle. Many participants agreed with the proposals’ ends but not their means:

- Focusing on the need for a framework that encourages good relationships that are not wholly transactional. For example, one participant suggested the skills and experiences of proposed RPB staff could be in line with the framework, with another calling for it to embed fair work principles as set out in the White Paper.

All parts of the commissioning cycle were deemed to be as important as each other, but any national framework would require teeth to ensure outcomes were regularly met, through robust accountability processes and evidence base. However, the commissioning cycle of Analyse, Plan, Do and Review could be greatly enhanced and strengthened by embedding the principle of co-production at each stage.

Other concerns focused on how Direct Payments would be included in a national framework, and participants would also like examples as to how the proposals would lead to more voice and control for service users, and when that would start to happen.

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

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

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

Again, people felt these questions were overly complex for consultation. However, 60% of those polled felt the proposals should also include continuing healthcare, though almost 40% felt they did not have enough information to be able to answer all elements of question 5.

Some participants argued that if there was no integration across Health and Social Care, perhaps it would be pertinent to discuss the need for a National Care Service akin to the NHS which would increase its status. With very little reference to health in the White Paper, it was felt that separating out health and social care needs would prove problematic as they interact uniquely for each and every person. From a women's health inequalities perspective if health needs were addressed earlier than there would be less reliance on accessing social care support.

Again, participants raised the need for more conversation, and to involve service users and carers, as many would argue that commissioning in social care should dovetail with commissioning in health.

While there appears to be an appetite for a national framework, whereby all stakeholders adhere to the same conceptual ways of describing what they are buying, participants felt that they also needed the correct data to be able to do that properly. This means less focus on consistency, but more focus on individual outcomes and a person-led approach – with a focus on care and support plans. It is thought that this approach would lead to better mechanisms for early intervention and prevention.

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

**Question 6a** If so, which ones?

This is the question that caused consultation participants the most difficulty, with 73% unable to answer the question, as they felt that they did not have enough information. Only 18% agreed that the activities of some existing national groups should be consolidated through a national office.

Participants also would have welcomed a list of existing national groups as part of the White Paper consultation. For example, it is not clear if Welsh Government is including the National Commissioning Board in their list of existing national groups, but it would seem prudent to include.

Participants were particularly vocal that Welsh Government must set out a clear evidence base as to how their proposals will deliver against the principles of the SSWBA, especially in relation to delivering equal opportunities and ensuring service users and carers have control over their lives. Currently, the argument has not been fully made and needs to be explored further.

***“We’re being asked to pronounce on details, when actually we need to be able to see that the technical detail put together by experts meet the needs that we are in a position to talk about. Otherwise, it sounds like a reshuffling of deck chairs to me.”***

**Consultation Participant**

**Other concerns included:**

- The need for any ‘national office’ to be appropriately named, such as ‘The National Social Care Office’, in order to ensure clarity of purpose and to give it an appropriate standing as the Office of the Chief Medical Officer.
- The potential creation of a two-tier system, with some needs being prioritised over others.
- How would it be mapped to ensure the commissioning practises of existing national groups do not overlap or contradict each other, especially in their impact on the various ‘care markets’?
- The accountability of RPBs shifting from local communities and service users to a ‘national office’, thus exacerbating existing problems related to representation and scrutiny, and compromising co-production.
- Where would the Citizen’s Voice Body sit?

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

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

This again proved a difficult question for participants, with 36% polled unable to answer, owing to a lack of information. That said, 42% did not believe that establishing RPBs as corporate legal entities would strengthen their ability to fulfil their responsibilities. Much of this can be explained by the current dissatisfaction with RPBs (see answer to question 3 and previous reporting to the Welsh Government by WCVA), with one participant who was actually in favour of creating RPBs as legal entities, seeing it as an opportunity for “*a big RPB shake up*”, pointing to the need to move away from controlling institutional behaviour in a review of all processes, systems practice, and culture.

Overall, it was felt that RPBs’ structures and ways of working need to be reviewed, before providing them with additional powers, though some participants felt some RPBs were better than others. On a practical level, if RPBs were to become legal entities:

- How would that impact on the legal status of representatives?
- Would it have statutory partners or have a group of directors?
- How would the interface between local and regional corporate body work?
- Would it mean representatives would no longer be the voice of their sector or population group and become a Director of their RPB? If so, this would put off some people from sitting on RPBs.

A related point lies in how external representatives would be selected and whether it would be by public appointment. If employing own staff, to what extent would this detract from the funding required by citizens? It is thought that it would result in limited representation

of volunteers and paid carers, as was the case some years ago when Welsh Government sought to establish Regional Learning Partnerships, but ultimately failed because partners were reluctant to relinquish power. There are fears that it would not result in a more responsive approach to communities' needs.

Some participants felt it *could* be useful if it led to more accountable monitoring and evaluation, without extra complexity or bureaucracy. Any new proposal needs to put at its heart the need for proper scrutiny and accountability of RPBs.

Participants raised the need for longer-term funding, suggesting that annual funding cycles do nothing to promote continuity or sustainability of services. It was recognised that sustainable services were key and that there was a need to consider what core services were needed at a local level and work quickly to identify and establish which of those services are crucial to support people, for example, carer support services. Some argued that it is unfair to assess the performance of RPBs as a result of the short-term funding environment.

#### **7a: Integrated approaches to volunteering**

Strategic planning and resourcing of volunteering as an integral component of health and social care should be encouraged and enabled at RPB level.

The White Paper cites (p 6) the example in England of Integrated Care Systems. NHS England is resourcing regional ICS systems to develop [integrated volunteering approaches](#) which address local population priorities and outcomes, by providing successful applicants with practical support and funding. A regional, integrated approach to volunteering of this kind requires joint working across public sectors and with third sector organisations. It encourages joint identification of **where** and **how** volunteers are best placed to provide care and support, based upon available evidence. It encourages thinking about how volunteers can move more easily between organisations, for example by developing shared recruitment and training processes. It encourages development of pathways by which volunteers can experience different working environments and pursue qualifications and careers in health and care, should they wish.

Volunteers are, in themselves, a force for integration, able to focus on people as people, without the constrained agenda of a professional service. They have a role which complements what statutory public services can do. They are able to address inequalities, for example by supporting individuals in ways in which friends and family might do, where neither family nor friends are available.

Volunteers, along with service users, unpaid carers, staff and members of the public, have insight into how public services work and where bottle necks are. RPBs would do well to share their challenges and invite their suggestions about ways of addressing these. Volunteers are an untapped resource for community care. COVID-19 saw a massive volunteer response and the inadequacy of existing channels to make effective use of this community asset.

During the vaccination programme Health Boards have mostly been reluctant to advertise for volunteer assistance knowing that if they do, they will be inundated with more offers than they are able to utilise. Given the need to rethink sustainable models of care provision, this flexible resource should not be ignored. Volunteers help to create community resilience. Experience of COVID-19 shows that where volunteering had previously been identified as a key element in civil emergency response and where time and effort have been invested in building relationships between organisations, volunteers could be more quickly mobilised. Voluntary sector organisations proved to be more agile in this regard.

RPBs are well placed to develop the best infrastructure to embrace and maximise volunteering initiatives that address care and wellbeing needs in local communities.

**Question 8:** Do you agree that real-time population, outcome measures and market information should be used more frequently to analyse needs and service provision?  
**Question 8a** Within the 5-year cycle, how can this best be achieved?

There is overwhelming support for real-time population, outcome measures and market information to be used more frequently in analysing needs and service provision. 78% of poll participants agreed, with only 6% against; 16% said they did not know, because they felt they had a lack of information.

It was felt that this question should be the starting point for further conversations, in agreeing meaningful outcomes based on qualitative and quantitative measures. It is vital that they focus on relationships and lived experience, looking at assets as well as need, rather than imposed quantitative KPIs.

In terms of a five-year cycle, participants pointed to the need for ongoing data collection, as that would encourage prompt changes to service delivery. This could involve taking regular information from frontline workers and service users and unpaid who serve the population locally rather than a greater reliance on quantitative data which does not give a rounded picture. This approach would require RPBs to develop new skills and develop improved relationships with the public, so as to obtain the necessary data, particularly for the most disadvantaged, and those with protected characteristics. This might be better met if RPBs looked at needs across health, social care, education and housing as they are important to provide a holistic approach. Ultimately, if there is any degree of efficacy in the support

provided, then changes in need will naturally occur, and so it is vital this is measured accurately and in a timely fashion, not least because it will help in developing better prevention and early intervention services.

Other comments include:

- The need for the five-year cycle to be shorter, as services come and go and we should be recording unmet needs or checkpoints during a five-year cycle.
- Questions around real time information, and how that would sit with commissioning decisions already made, as contracts would be already given.

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

**Question 9** what should these be?

82% of poll participants were of the opinion that further change would be needed in order to address the challenges highlighted in the case for change. All remaining consultation participants did not know how to answer the question, with many calling for more information and discussion. While the principles used in designing the proposals are in keeping with existing legislation and policies, all of which are broadly welcomed, there remains a gap between strategic bodies' processes and people's lived experiences, and that gap grows exponentially. These proposals do not result in a change to the 'top down system' but actually strengthen it. Missing from the consultation questions posed is the ability to flesh out the way the system distributes and exercises power. The case for change needs to be re-focused towards community first and work upwards.

There was some consensus that the White Paper is unambitious in its vision and goals, pointing to a recent paper published by New Local on 'community power', whereby the social care sector should be designed to be *'qualitative, long-term, small-scale, embedded in the community, related to individual outcomes, focused on improving, recalibrating relationships, pluralism not consistency and uniformity, human-centred, adaptive, and preventative'*.

There is still work to be done in developing a continually responsive, iterative service development system that uses a qualitative, adaptive and preventative model, which focuses on grassroots relationships to modify services in response to people's needs. National structural change of this kind takes 10 years to evaluate and by then it has changed again. The findings from the current evaluation of the Social Services and Well-being (Wales) Act, 2014 need to be considered alongside the case for change outlined in the Paper.

There is little mention of the support and additional value that the voluntary and community sector can bring to improvements in the development and delivery of the framework and subsequent care services. Yet, they often have the structure to offer the

wrap-around services that statutory services lack due to the structure of public services. For example, when Population Needs Assessments are developed, the parameters and timescales are challenging, and occasionally used as an excuse not to include voluntary sector data, which results in planning being based on an incomplete picture of need and of unmet or hidden needs.

Participants also pointed to other issues not referred to in the White Paper:

- The processes needed to fully support children, particularly disabled children, transitioning to adulthood, and what is required from schools to develop comprehensive and non-discriminatory transition meetings etc, for early intervention and prevention.
- Embedding human rights instruments in formulating these new proposals, specifically the UN Convention on the Rights of the Child, the UN Convention on Rights of Disabled People and the UN Convention on the Rights of People with Intellectual Disability.
- Reviewing current culture and behaviour in RPBs and ensuring co-production is central to all proposals.
- Looking at the current disparity in pay scales for similar roles within health, social care and voluntary sectors, to limit the blocking of power and responsibility sharing.
- Developing more representative RPBs with the involvement of more young people and communicating with the voluntary sector as a whole, rather than assuming a CVC or national voluntary sector representative equals voluntary sector representation.
- Creating community-led co-operatives, social enterprise (Section 16 social value alternative models) that would build on local assets (that are different in each locality) and create a useful preventative and early intervention framework.
- Health, social care, education and housing are meant to be joined up by the Public Services Boards, established under the Wellbeing of Future Generations Act, yet the whole question of the relationship between RPBs and PSBs remains unresolved.

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

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

It was again felt that it was difficult to answer this question, as there were too many unknowns, with no information or figures released relating to current costs, the proposed governance of RPBs or the regulations they would need to meet.

That said, most participants were of the opinion that it would be costly, with several concerned that proposals would create *'bureaucratic tiers sucking money away from front*



*line service delivery', with 'bigger teams drawing on monies that could be better used in preventative work and social care provision in the community'.*

Structural change has happened before and there has been no appreciable difference to service users' experiences, particularly those with protected characteristics. This is about outcomes, rather than costs. It was felt that the proposals could cost millions, but it means nothing if the outcomes remain the same as previously experienced. Information would be needed to determine if the proposals would make a tangible difference to service users and unpaid carers.

While there was broad agreement that proper co-production has a cost, it was suggested that, if RPBs were established as truly co-productive entities, there could be a huge potential cost saving implication, because services meeting people's needs would be more likely to be commissioned.

A proper fund for co-production would be welcomed, as that is fundamental to the success of any new proposals and the the success of the Social Services and Well-being (Wales) Act, 2014. It was thought that parity across Wales *'could only be a good thing'* but that it would be up to the people who receive care to evaluate the new system's success.

**Question 11:** We would like to know your views on the effects that a national framework for commissioning social care with regionally organised services, delivered locally would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.

What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

Participants felt that if the new proposals hone in on a local and individual level, and within communities, then the needs and required outcomes of Welsh language speakers would be naturally met.

Other participants used this question as an opportunity to raise concerns about meeting the needs of BAME communities, suggesting budgets for the Welsh language are significantly higher than for other languages even in areas where there is a larger percentage of ethnic minority communities.

***"I can count on the fingers of one hand the times I have been able to receive health care through the medium of Welsh, and my father has never received social care through his first language. That is not to deny the needs of other population groups, but that should not be at the expense of Welsh speakers (or at anyone else's expense)".***

**Consultation Participant**

A small group were of the opinion that *‘Welsh language isn’t the issue, as all standard commissioned services are expected to provide information in Welsh already, with an active offer already in place’.*

It was felt that problems existed because RPB staff, pulled in by public bodies, are not being held to account or challenged in relation to poor practice, and that there should be fair access for all, including community languages and BSL, for example. People felt it unacceptable to exclude people and the *‘system needs a proper shake up’* to ensure that service users and carers were involved in design of services from the outset. *‘Access is access’* said some participants, many of whom felt it vital that Government make the Framework accessible in all languages, owing to legal duties emanating from the Welsh Language Act and the Equality Act 2010. Others were careful to remind participants that a real problem exists for first language Welsh speakers, who are often far more comfortable speaking in their mother tongue, but that the *‘active offer’* feels *‘a bit perfunctory at times with no real genuine desire to engage and promote the language’*.

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

Broad agreement among participants that if services are driven by users’ needs, then the needs of Welsh language speakers should be met. (See previous answer.)

#### **4. CONCLUSION**

In brief the content of the White Paper is welcomed especially the need to unpick and simplify the social care market. However, there are concerns that what is proposed including creating RPBs as legal entities may not elicit service improvement and that it should be driven from the community upwards:

- What are the essential care and support services required at a local level and that can be provided by a range of organisations, formal partnerships or through Section 16 social value organisations to promote prevention and early intervention?
- What at an intermediate level when a citizen needs additional support above and beyond what can be provided locally and can be commissioned regionally.
- What specialist services need to be commissioned regionally and nationally?

Key to success is to avoid the crowded market which currently exists and there is broad agreement to remove the monopolization of the social care market through a workable and flexible social value commissioning framework.

To conclude it was felt that there is a need to:

- Learn from what works well and what has not to improve service delivery and quality of care and support services.
- Recognise that communities are diverse and have their own characteristics, strengths and assets. Therefore, a national framework and regional standardisation and commonality needs to take this into account and have the flexibility to respond to local need and citizen-led action, and know how that fits into improving people's health and well-being.
- Consider and build into a framework the interspace of community-based solutions and decide where a local strengths-based approach would fit.
- Ensure that there is an accountable process to hold RPBs and organisations across sectors to account for not co-producing with citizens (service users and carers) in the design of care and support services.
- Map the proposals against the core principles of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.
- Deal with the existing concerns related to RPBs previously reported and to ensure these are addressed before seeking primary legislation to provide RPBs with legal entity status.
- Accept that Care and Support Plans are a good starting point but there needs to be clarity as to how those plans inform a national framework.
- Recognise that measuring success from an outcome perspective (individual) is often fraught with challenges as different tools are used. While not wanting to promote standardisation:
  - There needs to be a flexible approach dependent upon the size and scope of organisations including the local/community based activity, and
  - a need to agree what valid measures could and should be used to compare and contrast across care and support services.
- Accept that price has been a dominant factor to the detriment in commissioning care and support services to the detriment of providing what matters to people and has made it difficult to grow and invest in Section 16 type organisations delivering alternative models of service delivery. While setting a fee methodology would be helpful it may not necessarily mean will be a greater investment in alternative delivery models and this element of work may need specific additional resources.

Finally, there was agreement with the need to be bold to drive service improvement and that the voluntary sector has key skills, expertise and strengths to contribute to a change

agend. Collectivism is crucial to move forward the intentions of the White Paper and that means ensuring that co-production is a the heart of what happens next.

WCVA will be pleased to discuss these comments further with Ministers or officials if requested.

For further information please contact Sally Rees (WCVA) [srees@wcva.cymru](mailto:srees@wcva.cymru)

*Sally Rees*

*WCVA National Third Sector Health and Social Care Facilitator*

*April 2021*

## APPENDICES

### Appendix 1.

#### POLL RESULTS

These results were amalgamated from both online consultation sessions.

	Total number of participants that answered (both events combined)	Yes	No	Don't know
Q1	44	91%	7%	2%
Q2	43	74%	5%	21%
Q5a	35	3%	60%	37%
Q6	33	18%	9%	73%
Q7	36	22%	42%	36%
Q8	32	78%	6%	16%
Q9	34	82%	0%	18%

**Appendix 2****REGISTRATION LIST** (not all attended but received a draft of the response for comment)

<b>First Name</b>	<b>Surname</b>	<b>Organisation</b>
Donna	Coyle	Wales Co-operative Centre
Sujatha	Thaladi	The Mentor Ring
Rhian	Stangroom-Teel	Leonard Cheshire
Jackie	Dorrian	CAVS
Anne	Newman	
Babs	Lewis	Nesta
Helen	Sinclair	NPTCBC
Hazel	Lloyd Lubran	CAVO
Stephen	Tiley	GAVO
John	Gallanders	AVOW
Helen	Smith	St John Ambulance Cymru
Eileen	Munson	University of South Wales
Anne	Morris	Interlink RCT
Stewart	Blythe	WLGA
Bernadette	Hurley	Moss-Rose Cottage C.I.C
Andrew	Cuthbert	Cardiff University
Beth	Evans	Carers Wales
Gethin	Rhys	Cytun - Churches together in Wales
Emma	Burke	Leonard Cheshire
Jake	Smith	Carers Wales
Miranda	Thomason	GAVO
Samantha	Nicholls	Hywel Dda University Health board
Maria	Cheshire-Allen	Swansea University
Helen	Allen	SHINE
Melanie	Hayes	Shine Charity
Adrian	Bailey	Swansea CVS
Adele	Rose-Morgan	SCVS
Luke	Venn	Spry Care
Susanne	Maddax	GAVO
Tom	Penney	Social Kemistri Ltd.
Steph	Shobiye	Autistic UK
Fiona	Liddell	WCVA
Ann	Camps	Macmillan Cancer Support
Linda	Newton	Cavamh
Amanda	Carr	SCVS
Bethan	Shoemark-Spear	Age Connects Morgannwg
Karen	Berrell	Joining The Dots
Ann	Westmoreland	CVSC
Kate	McCormack	Wales Co-operative Centre
Lowri	Griffiths	Marie Curie
Pat	Powell	Torfaen Voluntary Alliance
Amber	Demetrius	WCIA

Mark	Llewellyn	University of South Wales
Faye	Patton	Care & Repair Cymru
Sue	Phelps	Alzheimer's Society Cymru
Bill	Upham	Growing Space
Alex	Bowen	Breathe Creative
Sue	Leonard	PAVS
Paula	Lunnon	Wales Co-operative Centre
Angie	Darlington	WWAMH
Sandra	Anderson	AVOW
Johanna	Davies	Neath Port Talbot CVS
Clair	Swales	PAVO
Grace	Krause	Learning Disability Wales
Catrin	Fletcher	Hafod
Sarah	Lowther	British Liver Trust
Owen	Williams	Wales Council of the Blind
Noreen	Blanluet	Co-production Network for Wales
Cari	Jones	Fresh Insight Today CIC
Ellis	Owen	Neath Port Talbot Council for Voluntary Service
Lee	Ellery	
Lorraine	Morgan	
Lisa	King	Afan College
Simon	James	Interlink RCT
Rachel	Williams	Parkinson's UK Cymru
Mark	Llewellyn	Trustee, WCVA
Sally	Rees	WCVA

Health, Social Care and Well-being Planning Group  
Co-Production Network for Wales  
Fair Treatment for the Women of Wales  
Health, Social Care and Well-being Leads (CVCs)  
Resourceful Communities Partnership Reference Group