Age Cymru consultation response -

Rebalancing Care and Support

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

We agree that complexity in the social care sector inhibits service improvement; we believe that much of the complexity relates to the challenge of providing a service where demand far outstrips supply and against the backdrop of ever reducing funding levels. Funding levels impact greatly on commissioners' ability to plan for and meet the needs of those that need services. Despite the will of staff and leaders to provide good quality care and support as envisaged through the Social Services and Well-being Act, changes to date appear to have largely been small in scale, rather than wider, deeper improvements across health and social care services.

Our community calculator report recently found that though most older people in Wales are happy with the help they receive, 10% rated health and social care services as poor or very poor, with length of time that people have to wait before a GPs appointment or social care can be accessed as a major issue. Covid 19 has demonstrated the fragility of our system and how in the times of greatest need, systems are not sufficiently robust to protect the most vulnerable in our society. Any solution must involve appropriate levels of additional funding to support levels of need.

Though the population continues to grow and age, the provision of adult community-based services, care home provision and respite care has been falling year on year.[1] There are many areas of health and social care where there are issues that need addressing, but this cannot be done at the expense of acute services that are needed now and in the short term. It is difficult to see how improvements can be achieved without compromising existing care and support services unless significant additional funding is available to support real change.

<u>Needs Assessments for older people</u>

Enquiries to Local Authorities in Wales by Age Cymru found that there are significant geographical variations in the percentage of people aged 65 and over receiving care and support assessments. Of those that responded, the lowest figure was 1.5% of the 65 and over population and the highest was 23% (with the second highest being slightly over 10%)[2]. We are concerned that the low number of older people receiving

[1] Assessments and social services for adults in Wales, 2015-16, available at http://gov.wales/statistics-andresearch/assessments-social-services-adults/?lang=en
[2] Age Cymru Care in Crisis? 2017

care needs assessments within some local authorities is caused by their initial screening processes and that people getting in touch with local authorities' contact centres are being referred to third sector agencies without full consideration of their circumstances. Without access to a full assessment of their needs (and regardless of whether needs are met through statutory sector, private sector, social value sector, third sector or by friends and family), local authorities cannot hope to understand the full range of needs of the county's population. Appropriate service planning to meet those needs cannot be achieved unless all requests for an assessment are responded to. This would require the social care workforce to have increased capacity to conduct the assessments; another area that requires additional resourcing.

Carers' needs

There is an urgent need to examine the volume and range of support for carers. There are more than 384 000 carers living in Wales, representing 12.1% of the Welsh population.[3] Currently more than 6.5 million people across the UK provide care for family members or friends[4], with estimates from Carers UK suggesting that a further 3.5 million carers will be needed by 2037 based on current demographic projections[5]. Informal care provided by friends and relatives is by far the largest source of adult care provision. Its replacement would cost an estimated £8 bn - roughly equivalent to the whole NHS Wales budget.[6] The number of carers claiming carers allowance (for those under pensions age who care for someone for more than 35 hours a week) has doubled since 2003[7].

Carers UK conducted a survey at the beginning of the pandemic across the UK and updated this six months later. They found:

- 81% of unpaid carers were providing more care during the pandemic (up from 70% at the beginning of the pandemic);
- 38% are providing more care as a result of local services reducing or closing (up from 35% at the beginning of the pandemic);
- On average, unpaid carers are providing more than 10 hours of additional care a week; and
- 78% said the needs of the person they care for have increased since the pandemic began.[8]

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[3] S Yeandle & L Buckner (2015): *Valuing Carers 2015 – the rising value of carers' support* (Carers UK): p5
[4] Carers Wales (2014): *State of Caring 2014*: p3
[5] House of Lords Select Committee on Public Service and Demographic Change (14 March 2013): *Ready for Ageing?* (HL Paper 140): p82
[6] Cian Sion and Michael Trickey (2020) The future of care in Wales: Resourcing social care for older adults, Wales Fiscal Analysis, Cardiff University social_care_final2_aug20.pdf (cardiff.ac.uk)
[7] Cian Sion and Michael Trickey (2020) The future of care in Wales: Resourcing social care for older adults, Wales Fiscal Analysis, Cardiff University social_care_final2_aug20.pdf (cardiff.ac.uk)
[8] Caring_behind_closed_doors_April20_pages_web_final.pdf (carersuk.org) & Caring_behind_closed_doors_Oct20.pdf (carersuk.org)

Pre-Covid 19, many carers and those they care for did not receive help until they were at crisis point and by this stage the required intervention is significantly more costly and intensive than preventive measures implemented earlier. One respondent to our Community Calculator survey said,

"*Looked after mum-in-law with Alzheimer's, who was 94. Found it difficult to get any help from local council or services. Did get carers but very limited help, no other support groups, my husband and myself were mainly her only help."*

In order to address the needs of carers, the following service improvements are needed:

- Health professionals should ask whether individuals are carers during consultations to improve early identification.
- GP practices should adopt the Investors in Carers framework of good practice to develop carer awareness, using the Quality and Outcomes Framework option to keep a register of carers to identify ways of working that support carers.
- Once identified, GPs should offer carers an annual health check to explore any changes in physical or mental health and offer appropriate advice, support and treatment.
- The Welsh Government should raise awareness of the importance of carers looking after their own health, with flexible forms of respite care available to support this.
- Local Authorities and Local Health Boards should ensure that carers receive training for specific tasks that they conduct which potentially impact upon their own health and/or that of the person cared for e.g., lifting.

These service improvements will require additional resourcing.

Respite Care and support

The Covid 19 pandemic has drastically increased the burden on carers, the majority of whom have seen a vast reduction in respite care during the pandemic, if they have had any help at all. Prior to the pandemic, many carers felt – though they value the service greatly - that respite care services were not flexible enough to meet their needs, despite the good will of social care staff in trying to arrange this for them. Much respite care is arranged far in advance, with carers having fixed times for respite services to relieve them of their caring role throughout the year.

Research has highlighted the lack of understanding of the range of carers' needs, the paucity of available respite care and how barriers for carers – including a lack of appropriate respite services based on what people want - can mean those that need support do not always access it.[9] Given the increased burden on carers through the

[9] Microsoft Word - Respite Care in Wales Final Report v4 - untracked (londoneconomics.co.uk)

pandemic, it is vital that there is a focus on improving support to carers through any changes and this will need additional resourcing.

Domiciliary Care

Many of those needing the health and social care system's services who see what they need as a simple 'ask' in many cases, struggle to have their needs met due to a lack of sufficiency of availability of services appropriate to their needs. For example, some counties in Wales do not provide 24-hour domiciliary care services. It is very difficult to see how this cannot be a need for at least some of the older people in each area. If overnight care is not available for people that need it, this additional burden will either fall on to their loved ones, or not be met at all. The cared for and the carers' health can be compromised as a result and if care needs are not met this can hasten the need for residential care and other higher-level care and support interventions or worse.

Similarly, there are other issues with domiciliary care under the current arrangements as many people are unable to have care in their own homes at times that matter to them rather than the time slots that are available from a limited number of domiciliary care providers. This means that a significant number of older people with care needs are unable to decide for themselves what time they get up and what time they go to bed as this is dependent on when time care slots are available - an infringement on their civil liberties.

Again, these issues arise from a lack of resourcing to a range of support services, and not through the complexity of the system itself.

Residential care

Families can struggle to get a residential placement in the location they want and need for their relative. Though efforts have been made to reduce the volume of out of county placements for residential care, a lack of the appropriate type of care facilities often mean that placements are further than families would like, resulting in longer travel times and less frequency of visits than they would like. This affects the mental health of the resident and their family.

In addition, current arrangements where families have to pay top up fees over and above that the local authority will pay need change. We have heard examples from across Wales where families have been ill informed of charging arrangements and they have suffered through loss of finance through these arrangements.

When combined together, the issues covered above relate to the funding available to commission appropriate services relevant to older people and their carer's needs.

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

Tend to agree.

Current commissioning practices generally focus on discrete services, as opposed to being person centred. The system changes expected through the Transformation Fund and the Integrated Care Fund have yet to be realised. There is a need for commissioning teams to understand the holistic needs of the population, including differences needed at different life stages and under different individual circumstances.

The position regarding an over-focus on procurement varies across Wales. We have heard of examples where local authority commissioning teams had moved away from a focus on procurement and towards increased involvement of service users and groups representing them to commissioning of newer services with intentions to have more of a focus on person-centred outcomes. However, budget reductions combined with changing and more complex needs emerging through our ageing population hamper these efforts and a lack of resourcing is reducing commissioners' ability to make improvements. Whilst this white paper has a focus on market shaping, this cannot be done without additional investment as there is current fees are insufficient to attract newer investments.

We have had feedback from the care home sector that there is a definite focus on procurement over improved commissioning practices to meet the needs of older people within Health services. We have heard that there is a lack of understanding of the service that a person wants and needs, as opposed to what professionals believe to be the case purely on clinical evidence (i.e., a focus on the medical condition, not the person behind it).

The Cost of Care report highlights the discrepancies between the cost of delivering services by staff that are paid a Real Living Wage and supported in their roles and the actual hourly rates for care paid to providers. This is unsustainable and makes the market increasingly fragile. We have received feedback from service providers that commissioning teams are unsure of the status of various forms of commissioning guidance; whether certain forms are statutory or advisory and on which to follow in different circumstances. Though the 'Agree to Disagree' toolkit was introduced in 2018 and includes fee setting methodology, this has not changed service providers experience of contracting or assisted with fee levels to date that we have spoken with.

Commissioning teams across Wales now undertake higher volumes of commissioning and procurement than before. Previously different departments within local government undertook their own commissioning functions, but these have become more centralised in efforts to produce cost savings and standardise commissioning practices. Unless additional efforts are put into ensuring that commissioning teams have the breadth and depth of knowledge previously available, this can result in poor commissioning practices that these changes hope to avoid. Commissioning teams need to be able to understand the market, history and status of the various commissioning guidance documents such as:

- local procurement rules (which are often outdated and can actively work against good quality procurement and commissioning but that have a higher status than other guidance),

- ‘agree to disagree’ toolkit,
- understanding of where Part B exemptions for social care services versus EU procurement rules apply,
- public sector equality duty.

This list is not exhaustive. These are issues faced at local level. When combined with the need to commission at regional level with national direction, there will be a whole host of other issues to consider. Local authorities over recent years have reduced their internally operated care home provision and this is a move that local citizens are often opposed to. Considerations of home closures are difficult and can be opposed by local councillors for a whole host of reasons. It is unclear how these issues can be addressed under the proposals contained in the white paper.

It would be preferable to see outcomes focussed commissioning, through more flexible contracts for delivery based on what people want. One way to assist with this would be to have fuller involvement in a meaningful way of those who need services and their families to be involved in the commissioning cycle. Private, third sector and not for profit providers of care should also be fully involved in these discussions.

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

Tend to agree.

RPBs have a range of tools at their disposal with which to advance the transformation agenda. They have, however, experienced difficulties in joint commissioning due to the varying legal status of commissioning in their service areas, as well as local procurement practices that often work against the aims of service improvement and integration.

In terms of structure, private, not for profit and third sector service providers experience difficulties in having the sectors’ knowledge and experience heard at regional board level. There are inequalities in the number of public services compared with independent (private or third sector) provider services at the table. Requirements include that there should be at least one representative from the sector, but there are difficulties in that one representative being meaningfully able to represent the whole sector fully at meetings who is able to cover the range of services for the region. Further, many service providers are small in nature and lack staffing capacity to gain their sector’s views in advance of meetings, then physically/remotely attend meetings, and then provide feedback to all service providers in the region.

Service user-led groups and organisations representing them also have the above issues. These inequalities need to be addressed for RPBs to be able to fully fulfil their functions. The structure of RPBs therefore needs to consider how full engagement can be achieved and whether alternative mechanisms can be utilised more effectively.

Research suggests that success in integration of health and social care for the benefit of the population can only happens when certain conditions are met. These include that partners need a shared commitment and shared vision to transforming care and they need to able to invest time and energy to develop effective partnerships.[10] This takes time to achieve and given how stretched both social care and health services are, more does need to be done to support them in this. These conditions will not automatically be met through legal requirements, though they can assist with this if commissioners if health and social care leaders have already worked to improve joint commissioning and joint working.

We are concerned that a legal requirement may not produce improvements over and above 'box ticking,' especially given the strain that health and social care services were previously facing, and now further compounded through the Covid 19 pandemic. The time and investment necessary for the legislative process that this entails needs to be carefully weighed up against other options that are likely to produce improvements in the health and social care system.

If legislation is decided upon following this consultation it is important that any incoming legislation is assessed for unintended consequences. Legal requirements would have to overcome difference in governance, accountability and performance measures at local, regional and national level and take into account the complicated relationships across the sector both from service user, service provider and a commissioner perspective. They would also need to consider the negative impact that legislation could have on good front-line working relationships that exist despite a legal framework to support a focus on the needs of the service user.

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?

Neither agree nor disagree.

There are both strengths and weaknesses in having a national body looking at fee levels. Private, social and third sector providers of services to older people have concerns regarding how fees are currently set and there is some support for fees to be set nationally. However, this support is conditional on considerations of all costs of service providers and the full involvement on the setting of fees of service providers in Wales and upon the national body working on this in a timely fashion. If a national framework can not agree fees that are higher than currently, the current risk of private care companies going into financial administration remains and nationally this could be a larger disaster than locally and regionally.

[10] See for example Bäck MA, Calltorp J. The Norrtaelje model: a unique model for integrated health and social care in Sweden. International Journal of Integrated Care. 2015;15 http://doi.org/10.5334/ijic.2244; In this case the legal framework was both a help and a hindrance at different stages of the transformation journey.

It is important to recognise that the national framework for children's services did not happen overnight and a huge amount of work was needed over several years to develop it as there were so many issues that needed addressing. Similarly, the National Procurement Service was incredibly costly to develop, was lauded as the means of reducing system wastage and has not produced the cost savings that were expected. Achieving a framework for all adult services will need to be a longer-term goal. Consideration needs to be given as to which areas will require attention earlier and which areas are less of an urgent area to look at.

Care Providers have told us that during the Covid 19 pandemic, national direction and support was vital for the sector to get the support that they needed quickly to stay afloat when their local commissioners were not able to help them. This gives them some confidence that this may be a promising way forward for the future. However, as the consultation details, one size does not fit all and this needs to be recognised both nationally, regionally and locally.

In order for services commissioned for health and social care to be sustainable, fee levels need to be appropriate. According to Bolton and Townson (2018)[11], fees should be based on the actual cost of a high-quality service that:

- Is staffed by employees paid a Real Living Wage in order to provide continuity of support and reduce the high turnover of staff in the sector (especially private domiciliary companies)
- ongoing training and up-skilling of staff as the health and social care needs of our ageing population change
- appropriate levels of funding to prevent the deterioration of physical building and other elements.

In addition to setting fees for placements funded through health and social care, consideration needs to be given to the fees that self-funders pay. These are currently around 25% higher than those paid by health and social care commissioners.[12] Care home owners advise that these are more realistic fee levels, which they cannot do without in the face of fees that can often below the cost of service delivery payable by health and social care. Fee levels should be the same for self-funders as those paid from public funding.

Consideration will have to be given to the various categories of care that are currently contracted for. In the case of care homes, the various categories of care are used with which to decide fee levels. For example, there are fee differences for 'basic' residential care, nursing care and higher dependencies. The moves towards outcomes focussed commissioning requires careful consideration of what good outcomes look like for older people in residential care.

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[11] Bolton J and Townson J (2018) The Future of Domiciliary Care Microsoft Word - The Future of Domiciliary Care (6 April) - Final version 20180410.docx (housinglin.org.uk)

[12] The Future of Care in Wales: Resourcing Social Care for Older Adults, Cardiff University 2020 social_care_final2_aug20.pdf (cardiff.ac.uk)

Similarly for domiciliary care, respite care and day care type services, there are a range of different needs that people have that require staffing with differing levels of support and differing training areas, as well as equipment and other capital expenditure. These factors all affect the cost of care that the framework will need to consider.

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?

We tend to agree with this proposal as it will reduce the 'postcode lottery' of access to care and support across Wales. Service providers are concerned regarding how fees are set for their services, as this appears to be largely based on the budget available, as opposed to the cost of delivering a good quality service. These issues have been compounded in recent years through reduced public service budgets. Though the national drive to have fewer older people placed in residential care and receive support in the community for longer is good and is based on what people want, commissioning practices have not been able to achieve this change as well as expected. The care home market has reduced in recent years but there has not been a matching increase in extra care facilities and in domiciliary care services.

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

The purpose of CHC funding is, simply put, to allow those who have considerable and enduring health care needs to live as normal a life as possible. According to research, spending on CHC fell during the first half of the last decade but has since surpassed pre-austerity levels in line with the NHS budget for each year, suggesting that CHC funding levels might be as a result of resources available rather than level of need.[13] As such, pooling funding streams may provide a better service for those that need it as pooled budgets under the proposals within this consultation would be commissioned based on the local and regional population need. However, this should be in the context of a system that truly assesses a person's needs (and their carers) based on what matters to them, as opposed to assessments based on what services are currently available.

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

[13] The Future of Care in Wales: Resourcing Social Care for Older Adults, Cardiff University 2020 social_care_final2_aug20.pdf (cardiff.ac.uk)

Consideration should be given to the inclusion of extra care housing services as they provide services in line with the aims of the Social Services and Well-being Act.

Similarly Housing Association support provision for their tenants with vulnerabilities would benefit from national guidance and support.

Advocacy services should be considered for the framework as their outcomes are fully in line with the Social Services and Well-being Act. Advocacy services help with prevention and earlier intervention as the advocate can identify when care needs are changing and help the person make informed decisions about how to get appropriate support.

Tensions can arise between carers and cared for and between families and services. Advocacy can help improve communication which leads to much better outcomes. It can help people maintain their independence by personalising support in ways that focus on their strengths and desired outcomes. One in four people in a general hospital ward have dementia. In particular for this group, advocacy can help people chose appropriate care and support and potentially expediate earlier discharge from hospital. It can help people plan for their future and choose a care setting further in advance. This can also help reduce the burden on our health care system.

There are various forms of advocacy support ranging from those where there is a statutory duty to provide a service, through to volunteer-led/peer support advocacy services. Though there should be clear referral pathways to advocacy services in differing circumstances, this is often not the case.

By being part of the commissioning framework this would increase understanding of the range of needs for advocacy as well as assisting with the development of a referral pathway.

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

Feedback we have received from care homes suggests that having national leadership may assist to provide a more level playing field for services that operate across local and regional boundaries.

Through the Covid 19 pandemic, the large-scale changes in working arrangements by the whole care sector has by necessity relied on national direction to achieve anything like reasonable levels of care and support for Wales' older people. Separately, individual social care departments would benefit from appropriate national direction on improving working practices and sharing of good practice examples. This reduces each individual department in each local authority/LHB area 'reinventing the wheel.' This would reduce pressures on social care staff in different Welsh regions to be conducting similar work and allow them to concentrate on other areas.

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?

Neither agree nor disagree.

If arranged with appropriate care, diligence and detail then this may be the case.

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

Older people in Wales often feel like things are done to them with little consultation with them on things that have a huge impact on their lives. Where consultation does happen, this is often not in ways that are accessible to many older people (e.g., online-only consultations exclude the 51% of over the 75s that do not have access to the internet).

It is vitally important that regional boards involve older people at all stages in decision making that affects their lives when making service planning and commissioning decisions.

During this pandemic, public services have praised the third sector for their flexibility and ability to step up and assist to meet the challenges that the care sector faces in Wales. The value of the third sector needs to be fully recognised by Public Service Boards and be involved in decision making at board level.

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?**

The volume of work required to produce accurate, up to date population needs assessments should be weighed carefully against how much improvement in outcomes that users of services (and potential users of services who are currently unaccommodated) is possible from that work. Whilst population, outcomes and market information are important, there is a danger of this process being over complicated and add to the burden of preparation, which could result in a tick box exercise.

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

Agree.

The projected ageing population and the additional specific age-related health needs that this will result in mean the current volume of appropriate care home placements, cares support services and the associated community care levels will not be sufficient to meet ever growing demand. Demand can be managed to a degree through a focus on improved health as a means of prevention/delay of some age-

related conditions, but this will not be sufficient to meet growing demand and improved health initiatives can only produce change in the longer term.

9a- what should these be?

Different ways of more appropriately identifying health and social care needs should be considered. Whilst Welsh Government have recently made a statement on different ways to fund social care following research and information gathering on different options, increased service integration between health and social care services will certainly assist with meeting the shortfall in the longer term.

This consultation focuses on legislative changes that are intended to improve the health and social care system. As previously stated, we are concerned that the focus on legislation and the time and resource implications that this would entail may still not produce improvements if legal loopholes are left that allow both social care and health services to continue to contract separately and so not produce a more holistic, efficient system of health and social care.

There are examples from across the world where legislative change was not needed to produce huge improvements in health and social care integration for the benefit of the whole population.

In Canterbury, New Zealand, health and social care had similar concerns to Wales and the UK regarding the pressures on services of an ageing population. In 2007 their health system was almost NZ$17m in deficit on a turnover of just under $1.2bn was on track to make a $8m surplus in 2010/2011 in the year the area was devastated by an earthquake that through necessity sped up changes in their health and care system.[14]

Based on ‘one system, one budget’ the goals adopted were the same as we wish to see for older people in Wales:

- services should enable people to take more responsibility for their own health and well-being.
- as far as possible people should stay well in their own homes and communities.
- where people need complex care, it should be timely and appropriate.

The system claims to have saved more than a million days of patients waiting for treatment in just four clinical areas in recent years. Fewer older people are entering care homes and more are supported in the community.

Key requirements of change were:

- those in the health system, whether working as public employees, independent practitioners, or private and not-for-profit contractors – had to recognise that there was ‘one system, one budget;’

[14] Timmins N & Ham C (2013) The quest for integrated health and social care A case study in Canterbury, New Zealand The King’s Fund The quest for integrated health and social care: A case study in Canterbury, New Zealand (kingsfund.org.uk)

- Canterbury had to get the best possible outcomes within the resources available, rather than individual organisations and practitioners simply arguing for more money;
- that the goal was to deliver 'the right care, right place, right time by the right person' – and that a key measure of success was to reduce the time patients spent waiting.

Those involved with changing the system are crystal clear that this has to be so much more than 'lip service' – a true commitment of time, energy and resources is needed to make this work and cannot be done unless all are completely on board with changes. One key enabler of change identified involved every person within the care system being able to offer suggestions for change. Another was that all were assured that if they produced cost savings through their efforts, this money would not be taken away but instead could be used to improve existing services or expand out to area that had not been previously covered.

There was recognition that the largest are of waste in the system was in patients' time – by focussing on reducing this they made the largest improvements in care. Part of this improvement was through investing in a fully functioning, integrated patient care management and referral system. Referral times improved and over time the volume of inappropriate referrals dropped though increased training and joint working.

These huge improvements did require difficult conversations and decisions and Canterbury are clear that these improvements are very hard to achieve.

In Sweden the Norrtaelje model has produced improvements in that region in a similar way. Their shared approach to policy and financing created a climate that allowed better integration of resources and staffing that provided an impetus for developing the information technology and documentation strategies that enabled integrated care. It broke down traditional barriers between health and social care. Key to the approach was a decision that all providers, public and private, who want to serve the population in the area must act within an integrated chain of home care services, health care and rehabilitation.

It created the right mix of services – including preventative services – that focused on clients making better transitions across the sectors.[15] Though the model was not solely focussed on services for older people, improvements to care and support were realised. When the model was independently evaluated it demonstrated cost savings; the region had climbed from 171st place nationally to 61st place in terms of the difference between net costs and standard costs of care. Specifically, home help services for those aged 65+, the region moved from 206th place to 29th place.

[15] The Norrtaelje model: a unique model for integrated health and social care in Sweden - PubMed (nih.gov)

Given the crisis seen in health and social care over the last year, it is to be hoped that the pandemic has acted as a driver for real change. However, the exhaustion of the health and social care workforce and backlogs in work may mean that changes are harder to achieve. Social care and health services expect to see increases in waiting lists as services open up following the pandemic and how these can be accommodated whilst making large scale change without additional resourcing is difficult.

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

Whilst we recognise the costs faced by public services in delivering partnership commissioning and delivery, the costs to third sector services in engaging appropriately with the regional partnerships should also be considered. Small and medium sized charities and private companies delivering care in Wales struggle to have a meaningful voice at regional level. It is important that those services who work closely with older people and their carers have opportunities to shape service delivery. The costs that providers incur should not come out of funding intended for front line care that their services are commissioned for.

With the development of a national office, Welsh government need to ensure that costs incurred from this potential development will in fact realise change and not become additional bureaucracy.