

St Mungo's

Response to 'Shaping the Future of Care Together' Consultation

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About St Mungo's

St Mungo's is the main provider of services for London's rough sleepers, as well as to other homeless populations. Over the last ten and more years, central government has launched a number of initiatives to reduce rough sleeping. St Mungo's is the only third sector agency to have been involved in each of these programmes.

We run a comprehensive range of housing (shelters, hostels, high-support projects and independent flats), with ancillary services from street outreach to resettlement support, backed up by drugs, alcohol and mental health specialists. Every year we help more than 10,000 homeless and vulnerable people find responsive and integrated solutions for problems with housing, employment, training and health.

A fundamental element of our approach is our *Work and Learning* programme, which is the largest such programme for homeless people in Europe. It consists of an integrated range of a dozen projects stretching from engagement through training to employment. Each year we help roughly 100 people into sustainable jobs – and behind that headline figure are the 2,000 other unemployed men and women whom we help to improve their employability through *Skills for Life* and *Skills for Jobs* training, as well as volunteering and other forms of short-term work placements.

We believe that work is central to human identity, and promote its benefits wherever possible. We have a unique track record stretching back more than 20 years, and the clarity of purpose to project this forward into the future. The particular challenge for us – and, we believe, for government – is how to transform the unemployment rate in our hostels. Twenty years ago 86% of our hostel residents were in some form of paid work. Today that figure is 4%.

This represents a shocking failure of policy. We are encouraged by the tone of the Green paper, which identifies welfare dependency and makes some radical suggestions for tackling it. In some areas we think it does not go far enough in its prescriptions for tackling entrenched unemployment. We are determined to bring down the unemployment rate in our hostels, but we need government help to do so. We hope that the Green Paper can be just the launchpad we all need.

Introduction

We welcome the Government's bold aspiration to create a National Care Service.

St Mungo's works with vulnerable adults who have become rough sleepers, homeless, or offenders: most have either mental health, physical health and substance use problems, or all three; many have histories of such problems going back into their childhoods and indeed infancy. Our services fall within three categories - prevention; emergency services; recovery – and straddle health, support and care.

The Green Paper states that *'Care and support describes the activities, services and relationships that help people to stay as independent, active, safe and well as possible, and to participate in and contribute to society throughout the different stages of their lives'*. The National Care Service would do this by focusing on, amongst other things, Prevention, Joined-Up Services, and Personalised Care and Support, all things we have campaigned for and wholeheartedly support. Such a system, if effective, and effectively joined up with health, the benefits system etc as the Paper outlines, could end homelessness and rough sleeping, and vastly reduce offending rates, within a generation; and in the meantime provide hope and recovery to those whose lives have already been damaged.

We also wholeheartedly endorse the statement that *'It is better value for money and better for people to provide a good-quality service that keeps people as well as possible, than to provide poor-quality services which mean that people need other services later'*. The current focus on narrowly-defined short-term input costs as opposed to overall cost of outcomes is detrimental both to the clients and the broader economy, and mitigates against providers who focus on high quality provision. This Green Paper is precipitated by a demographic time-bomb – 1.7 m extra people needing care by 2026. It's worrying that no thought has been given to who will provide this care. Looking after elderly people, who can be both frail and demanding, is not easy. There is no suggestion that the shift will be away from Care Assistants. Do we want a minimum-wage workforce, with the declining standards which that suggests? And will this have a knock-on effect on other sectors of care and support, such as our work with homeless people and other vulnerable adults, where we pay considerably more than the minimum in order to provide a skilled workforce that can enable higher levels of support? And how does this square with the above statement about value for money?

We have some overall reservations: the Paper reads rather as a response to the anticipated funding crisis in care and support for an ageing population, rather than as a blueprint for a true National Care Service. It is not broad enough in its scope: where are the sections on children, people with mental health problems, people with learning difficulties, offenders, the homeless, and all the other range of vulnerable people who need support and/or care? Although the issues around providing care and support for older people require attention, they are not synonymous with national care and support needs.

The Paper states that *'The Government believes that the care and support system should be fair and universal'*. We agree. Universality is the principle that underpins the NHS and its values more than any other, and is what makes it, at its best, such an excellent service. However, the Paper goes on to then to talk of 'national assessment' and 'those who are eligible' and so on. The message of universality is not clear. Is this Paper dealing with care and support as provided by social

services departments currently – which is restricted in most places to only those requiring very high levels of ‘critical’ need? Most of the people we work with, although they have very high levels of need, receive no service at all from social services. Does it include all the support and care provided under schemes currently funded through Supporting People? There remain many people in need of support and care who do not receive support through any mechanism except their own social networks: how will this element be included: will it be used to assess that they do not ‘need’ statutory support and care? What is meant by ‘universal’ and what current support systems are included in the scope of this Paper needs clarifying.

Assessment is keenly political, and more needs to be said about how this will be done. If people are assessed as having a need in one area, and this is (as the paper says) ‘portable’, then assessed need must be met by any area where the person then resides or goes on to reside: this would need statutory force to overcome local connection arguments and localised commissioning. It is important that the lessons of Community Care are learned, when funding went to the provision (outer London) rather than to the people (inner London). Inner London boroughs complain they are magnets for needy people, and that they should not have to pay for people who they consider have a connection elsewhere: the logic of portability is that people can access services wherever their need is assessed. We want the white paper to state explicitly that, if people are assessed as being in need, they should be able to receive the service in the area where they currently live, and not have to travel e.g. hundreds of miles to their birthplace in order to get it.

Who does the assessments is a crucial question. There is an incentive for budget-holders to assess people as not requiring services if they need to protect limited budgets: this happens currently. The SCIE suggested that others could assess, including third-sector organisations and carers: proposals around who assesses need to be clarified and consulted on. This is made even more complex by the emphasis on joined up working across e.g. health, care, support, the benefits agency and housing: it requires either complex assessments by a panel or extremely skilful multi-talented assessors, or an acceptance of universality so that need is met rather than assessed for eligibility, for this to work. As healthcare is free at the point of access but social care is likely to be means-tested, the question of what is healthcare and what social care will continue to bedevil joint working and joint commissioning, and assessments will be part of the turf wars. Much more thought on how assessment would work is required.

Following on from these points about universality and assessment/eligibility, we have some concerns about whether the prevention agenda will be taken seriously in real, as opposed to rhetorical, terms (especially at these times of budget-cutting). Schemes that have high access tariffs like social services do not work effectively in prevention: the whole point of prevention is to stop people reaching ‘critical’ levels. But if the criteria for provision against assessed need is much lower than critical, then many more people will be entitled to support and care. We think this would be cost-effective – but only over time. The truth is that upstream interventions cost more in the short term because the downstream interventions cannot be decommissioned for several years. This truth requires thinking through, but the ‘fair funding’ section of the Paper only discusses care for the elderly.

We welcome the emphasis on ‘joined up’ approaches to support and care, but our experience is that joined up approaches are extremely rare (again, especially in tight budgetary situations) unless there are joined up budgets. To provide

comprehensive support and care for rough sleepers with trimorbidity, as we do, requires up to 7 commissioners to commission: this is impossible for us to coordinate and is not coordinated by anyone else (and certainly will be impossible for the user of self-directed support to coordinate!); and frequently the work of one commissioner is undone by the work of another, with each protecting their own budget and working to their own agenda and targets. This is a hopelessly inefficient and ineffective way of doing things, and of course brings with it extremely high transaction costs. The Paper says that better joined up working '*does not necessarily need to involve structural change*': our view is that it does. At the very least it certainly involves a common set of priorities, and these rarely emerge from unaligned structures.

We also welcome the inclusion of the benefits system, and the idea of more joined up working between the benefits agency and health, support and care systems. The paper could usefully focus more on work and benefits, though; we understand this is not an issue by definition for the retired older people the Paper focuses on, but for many people on disability benefits the ability, or inability, to work is a huge issue. More support for people in and into work is crucial, but also better integration of work and benefits (why has integrating tax and benefits dropped off the political agenda completely?). It remains true that the benefits system currently keeps many people out of work.

Response to the specific questions

1a) We think that the six priorities are right, but that there should also be a statement of **key values** (as there was in for example in the New Horizons consultation document) and a declaration of **universality**, setting out what that means for the national Care Service. The Service will inevitably be associated with, and to some extent be seen to parallel, the National Health Service which does have a specific declaration of universality.

1b) We think that much of the prevention, assessment and joining up workstreams could effectively be incorporated into primary care services with a wider remit. Rather than polyclinics we would have polysystems emanating from a hub where people with health or social care problems (usually intertwined anyway) could go to find support, care, treatment and advice. At the same time, not everyone wants to go to or use their GPs, so primary care could be taken out of the GP surgery and integrated in community-based care and support centres.

There remains a serious problem, however, with some services being means-tested and others not: it is far simpler administratively to manage and deliver a universal system. More thought should be given to the cost-benefits of this. In the longer term, we think it would be economically advantageous to deliver high quality care and support universally. It would, as some of your respondents have already said, be a much better way of reducing overall costs than waiting until problems reach critical levels and then trying to find the least costly way of dealing with them. It would also contribute to tackling health inequalities and to the construction of a fairer society, key Government objectives.

2a) We agree completely.

2b) In practice, you require common assessment or self-assessment or a joint single assessment based on *need*. If some needs will not be met because of means-testing or high eligibility criteria, this will distort the pressures on other services that do offer universal care (notably the health service, but also other agencies – we work with people with very high levels of need but who have been denied services by social services for example).

Every reduction in universality increases the money diverted from meeting need into bureaucracy and monitoring of eligibility. This is the system that produces Baby Ps.

Delivery would be through polysystems emanating from health and social care hubs, with roots in primary care but branches in social care and support and rewarded through achievement of financially and socially effective outcomes (i.e. payment by results, with success measured in e.g. a) client agreement that their problem has been resolved and b) reduction in calls on the public purse following intervention).

2c) The barriers are commissioners whose job is to protect budgets: while budgets are not joined up, whole outcomes are not valued by the contracting system.

Commissioning is also rarely innovative: commissioners do not have the time, and are pushed by national targets, guidance and politics into commissioning a certain set of services. Major statutory services have big political weight which is used to ensure their recommissioning, rather than the commissioning of client-focused problem-solving programmes, which is more complex and uncertain. It is much

easier to commission 'pathways' that users must then follow than it is to commission to the directions that users would like to go in themselves.

Commissioners are also constrained by national targets and directives that work against each other, such as short-termism and prevention, the benefits agency and getting into work, arguments about what is health and what social care, or about eligibility criteria. The promotion of local authority autonomy has also restricted joined up working, as accessing resources across boroughs becomes more and more difficult.

Merging Local authorities and PCTs would be helpful; in London reducing the number of authorities would be particularly helpful.

Throughout the Paper, 'care and support' are used as if they were joined together in some intrinsic way: currently Supporting People specifically excludes the possibility of delivering care and support. Is it the intention of the Green Paper to reverse this policy?

The key to this is that service delivery is not needs-led, it is service-led, and therefore the delineation of services and the hierarchies they work within determines joint approaches. If services were needs-led – in other words, there was a duty on the local authority to meet the needs of people presenting in its area – and one of the required outcomes was the reduction of long term overall costs, then solutions would be found, as long as there were a single budget from which to find them (which makes us think of the Total Places pilots).

3a) Comprehensive. It is fairer, and straightforward at the time that it matters: when people are in crisis, as they tend to be at this stage, the last thing they need is an argument over what is or is not eligible, or an examination of their finances based on a desire to exclude them – it merely adds to their stress and worsens their condition.

3b) No. there should not be a decision on how much people get, but rather on what services they need. Cost of these services will vary from place to place (for example, costs in rural areas are likely to be higher than in big cities), but if the National Care Service is to provide universal national support and care then it must provide the care and support required consistently to meet the same set of needs whether a person is in Moreton-in-Marsh or Manchester. What meeting those needs costs in a particular area will account for the amount of money, not some nationally-set tariff which will inevitably create inequalities.

We also think that funding for a National Care Service would have to draw on a range of budgets as budgetary separation is one of the biggest obstacles to effective joint working. We suggest that the funding of the National Care Service could usefully be considered as part of the Total Places pilot (in a piece of joined-up working by the Government!).

Summary

We welcome the idea of creating a National Care Service. We think it is a bold initiative. But to be truly effective and efficient, we believe it needs to be a radical creation as well, as the National Health Service was. Like the NHS, it needs to be universal, and needs-led.

We welcome the thrust of much of the Green paper, but think that there are many areas where more thought and consideration need to go into it; and that how it affects other groups than the elderly – in our case, homeless people, rough sleepers and short term offenders, but also people with mental health problems, children etc etc – also needs further consideration.

We also think that the mechanisms for delivery need further thinking through, and that structural change would be required to achieve the joined up working that would bring the cost-benefits that could potentially fund much of the service.

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