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Talking about COVID-19 and Commissioning

Members of SCIE's co-production network helped review SCIE's COVID-19 commissioning guides in November 2021. Their insights are reflected through the updated guides. This section summarises the conversations and reflections shared by these experts by experience during group discussions. These are individual views, shared as part of the conversation, and specific points do not necessarily represent the view of all members of the group. They help convey the range of ideas and perceptions that will be of interest to commissioners and which they will be seeking to understand in their own areas.

What impact has COVID-19 had on how people view social care?

- Technology is playing a much greater part in the delivery of social care; a positive development overall, but with caveats:
    - Will it replace face-to-face interactions? Monitoring visits are valuable for predicting problems and avoiding crises – but less effective online?
    - Confidentiality concerns – although with password protection for exchange of documents, it could be more secure.
    - Has it perhaps alienated further those who most need to be reached – digital poverty is still a huge issue.
    - We also need to be cautious and remember that even using the telephone won't work for everyone – e.g. conducting a benefits assessment for an older person with dementia.
- Technology needs to be used in addition to face-to-face interactions and support, and to reinforce connections.
- COVID-19 has highlighted the loneliness and isolation of those who rely on social care. Has social care been too slow to respond to the challenges and opportunities, and missed chances to connect people more? Voluntary services have stepped up, but it is hard for those confined to their homes, and social care services can end up prescribing a person's daily routine. Perhaps it's more accurate to see it as 'asocial care'?
- Alternatively, there is a sense that health and social care have adapted impressively, and continued to provide responsive and effective services that are well-led. Why did it take COVID-19 to show that things could be done differently?
- So many people have experienced bereavement and tragedy – particularly in care homes. This has highlighted issues around grief and loss.
- There has been an increase in hate crime, harassment and intimidation via social media – as people became more isolated they made greater use of social media, and for some this has resulted in hate crime and an ineffective response from the police.

Has COVID-19 affected how those who use social care are viewed?

- A sense of less patience within society? Rates of anxiety and depression are much higher, which will impact mental health services – 'a ticking timebomb'. There is likely to have been an impact on physical health too, from sitting at home.
- Initially there were many stories that would elicit sympathy; also, an awareness perhaps that we all have links with social care at some point. Perhaps some resentment too? The focus on older people in care homes and the need to protect them created some backlash and ageism over time.
- There were early incentives to help others, but as restrictions eased these fell away – people became less patient with others and moved away from this sense of a communal effort.
- Built up frustration has been seen in actions such as a refusal to wear a mask – compassion fatigue – 'We've done enough'. However, older people are 80 times more likely to die and younger people not always recognising this. Could result in people becoming more lonely?
- Not everyone experienced the pandemic in the same way. Inequalities were magnified.
- There is not enough differentiation made on the basis of vulnerability – blanket assumptions about vulnerability are made; people are also made more vulnerable by being isolated or fearful.
- There is value in the social model – what is there already out there that will support people? Thinking about the bigger picture. Time and connections can reduce the demand on GP services – 'People need people'.

The role of the community in the COVID-19 response – where is that at now?

- The community stepped up but this effort doesn't seem to be ongoing – perhaps that's OK, as maybe it's not needed in the same way now?
- It is so important for people to be able to be part of a community, connecting and giving – everyone can contribute in some way. There are links to the five ways to wellbeing; connections are possible, but many are still excluded.
- Many people did make the most of what it was possible to do during the earlier stages of the pandemic, creating new WhatsApp groups and building new connections in their communities; it will be valuable to continue that.
- Identity politics – language is being challenged and correct terminology emphasised.

What are your thoughts about commissioners/commissioning?

- How aware are commissioners of current research? Plans should be informed by up-to-date guidance and learning.
- The commissioning process is not transparent enough – current service users should be involved alongside topic experts. We need to address the power imbalance and be able to hold commissioners to account. Involvement is not working as it should – there is a sense that commissioners don't 'get it'.
- Commissioning is also not strategic; there isn't enough due diligence, governance or scrutiny.
- There is a disconnect between commissioners and people using

services. The aims and objectives of services are often completely removed from what those using the services want/need from them. This makes it harder for staff too.

- Services tend to be too prescriptive – not based on people's experiences and wishes; not person-centred; not based on values and principles of co-production.
- Are the right people involved in consultations? People are often unaware of the opportunities to be involved. Changes around integrated commissioning confuse people – clearer information is needed to empower them.
- Service bids are not anonymous – the process of commissioning social care services can be open to corruption, based on existing links between commissioners and providers.
- Intelligent commissioning is needed – listen to **all** communities and their own views of their needs.
- It is really difficult to get any answers – being an empowered service user tends to affect how you are seen; social care commissioning also struggles with the notion of service users as empowered citizens who have their own ideas about how to do things, or have set up or arranged their own services .
- Could there be a bigger role for CQC around social care commissioning?
- There are some good examples of commissioning and co-production – but why doesn't it happen well elsewhere?
- The commissioning cycle should start with an analysis of needs and gaps, but instead the financial constraints are resulting in a focus on delivery and making ends meet.

How do we do things better?

- Through dynamic, ongoing opportunities for continuous involvement.
- Appropriate reimbursement for service users' time and expertise, with a choice as to how that reimbursement is made; it should always cover any costs in addition. Involvement is often cheaper and easier now it can be done virtually. Proper reimbursement results in effective contributions.
- Better governance around involvement – need to avoid 'king making' (e,g, situations where one or a few people have a lot of say or sway, despite others having different views). Better inclusion is needed and commissioners need to make sure people from a range of backgrounds and experiences are part of decision-making
- Investing in people; enabling access to learning and training.
- Involvement from the earliest stages – this is currently rare.
- A willingness to hear 'unpalatable views'.

Hopes for the future/messages for commissioners

- Start with a blank canvas – get into communities, talk and listen; aim for a long-term, strategic, transparent approach that enables wide community involvement. It's our human right to talk about care and treatment, but they aren't listening.
- Freedom of expression; multi-disciplinary approach; enable voiced dissent; trust; feeling listened to.
- Robust public governance; people for involvement, scrutiny and audit.

- More integration from the inception of ideas, or even earlier – what to consult on? More involvement throughout. Ask ‘Have you consulted?’, and if not, why not?
- Commissioners need to be more involved with the inspectorate (CQC). There needs to be more transparency and equity of commissioning power; this is so services can appropriately fit both known and unknown needs, especially those from seldom-heard communities.

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The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
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