Consultation response: Vulnerable Older People's Plan

Local Government Association and Association of Directors of Adult Social Services

September 2013

About us

The **Local Government Association** (LGA) is here to support, promote and improve local government. We will fight local government's corner and support councils through challenging times, focusing our efforts where we can have real impact. We will be bold, ambitious, and support councils to make a difference, deliver and be trusted.

The LGA is an organisation that is run by its members. We are a political organisation because it is our elected representatives from all different political parties that direct the organisation through our boards and panels. However, we always strive to agree a common cross- party position on issues and to speak with one voice on behalf of local government.

We aim to set the political agenda and speak in the national media on the issues that matter to council members.

The LGA covers every part of England and Wales and includes county and district councils, metropolitan and unitary councils, London boroughs, Welsh unitary councils, fire, police, national park and passenger transport authorities.

We work with the individual political parties through the Political Group Offices.

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The **Association of Directors of Adult Social Services** (ADASS) represents Directors of Adult Social Services in councils in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of other responsibilities for the commissioning and provision of housing, leisure, library, culture, arts, community services and a significant proportion also hold statutory children's Director role.

A note on our response

Our joint response does not strictly follow the consultation questions. As some areas are of less relevance to local government our response instead provides a general commentary on the issues, making the links to other live policy agendas which we are closely involved in.

The policy context

We welcome the ambition to provide excellent care for vulnerable older people and an emphasis on the integration of services as a way to provide this. Integrated services are much more likely to improve vulnerable older people's health and wellbeing and ensure that they are both safe and treated with dignity and respect. We agree that services need to work with older people as a whole; as individuals in their family context and their neighbourhoods, not as a series of isolated problems.

The £3.8 billion health and social care Integration Transformation Fund (ITF) announced in the spending round for 2015/16 will be important in this respect. Adult social care activity can help reduce acute hospital activity, delayed discharge and emergency readmissions and shifting to more cost effective community settings will further help improve outcomes and save money. One of the biggest potential areas for savings is through more effective care for individuals with long term conditions, most of whom are older people with a variety of needs that require an integrated response. Getting this right will avoid inappropriate hospital admissions and improve hospital transfers.

Whilst the ITF is not all new money, and has to be seen in the context of an extremely challenging spending round for local government overall, this funding – and the message behind it – is positive. We are developing a comprehensive set of tools and good practice to assist local authorities and their partners drive forward local work on integration to make real improvements in service quality, outcomes and cost effectiveness.

The LGA and ADASS are working closely with NHS England and the Department of Health and Department for Communities and Local Government to shape the way the ITF will work in practice. We have also established a working group of CCGs, local authorities and NHS England Area Teams to help us in this process. By working together we can move toward fuller integration of health and social care for the benefit of the individual and the public purse. In this way, and subject of course to its success, we see the ITF not as an end in itself but as a means to a more significant pooling of budgets longer-term.

The LGA and ADASS also lead on safeguarding policy and improvement networks that reflect the ambitions of the NHS mandate to provide a consistently safe and high quality service for vulnerable older people. Together, we are committed to preventing and reducing the incidence of abuse and neglect of people in need of care and support, and to improving the outcomes for people when abuse or neglect has occurred. We work with our constituent members to ensure that local implementation is effective through integration, person centred care and sector led improvement.

Realising the aspiration

The role of GP's in supporting people to stay healthy and taking a proactive role in managing the health of their local populations is clearly important, as is the potential benefits that may be realised from local authorities taking on public health responsibilities. Local authorities and the health sector have a shared interest in supporting and safeguarding vulnerable older people.

Support and services need to be designed around people, not organisational structures of boundaries. Effective support to vulnerable older people requires true coproduction, with services designed and developed with individuals. We must give vulnerable older people control, placing them at the centre of their own care and support, and making their dignity paramount. Doing so will help support the provision of better services that improve individuals' quality of life.

The LGA and ADASS recently signed *Integrated care and support: our shared commitment*, a framework that outlined the need to create a culture of cooperation and coordination between health, social care, public health, other local services and the third sector. The commitment also recognised the importance of better information sharing and the potential presented by new technology and shared information. This can help local services to plan more effectively and will help doctors, care professionals and others to improve access to services and give people far better and more tailored services.

We believe that the integrated care Pioneers will also provide important learning on how to achieve the scale of change that is required for integration. Our work on an integrated care toolkit, including an evidence review of existing knowledge on integrated care outcomes and an overarching value case for integration, will also be key tools for the sector.

Specific comments

- Policy continuity: we recognise that a balance needs to be struck between maintaining current services and shifting resources away from the acute sector. However, it is important that there is continuity between different initiatives; the £500 million fund for relieving pressure on A&E could, for example, appear at odds with the ITF vision. Consistent messaging is important.

- Pace of progress: the Pioneers process has demonstrated the significant interest in the integration agenda that exists locally. However, we need recognition that the pace of progress will vary from area to area in line with different services, opportunities and relationships.

- Mental health services: positive local workforce attitudes and behaviours to help ensure that people with mental health conditions receive person-centred and coordinated care is important. Dementia wards at hospitals such as the Royal Wolverhampton provide good models of dedicated dementia wards with outreach into the rest of the hospital and good links with social services.

- Sharing data across care settings: changes in both professional attitudes around people's control and expectations of data sharing may need to change for benefits to be realised. Different systems have emerged in different services, often reflecting different cultures within services. There could be real benefit in seeing forerunning local areas leading by example on data sharing and digitalisation.

- Greater access to GP and integrated out of hours services: international case studies demonstrate the good outcomes attached to multi-disciplinary teams managing cases closely with general practice – particularly for patients with long-term conditions and where a range of consultation mechanisms are available for patients to access the most appropriate care.

- Culture: the work of National Voices and Think Local Act Personal in defining integrated care from the perspective of the individual is helpful. Signing up to the principles of the definition could be something that individual services and hospital wards could do. The voluntary sector clearly also has an important role to play in working with statutory sector partners to develop a more caring and person centred culture.

- Improving standards: improving standards of health care could have a positive impact on the need for social care, for instance in the treatment of people with strokes, continence problems or dementia. Intermediate care could also be used much more effectively, for instance to treat continence problems in older people who leave hospital so that they do not need to go into residential care.

- Urgent Care Boards: UCBs can play an important role in the whole system approach to tackling emergencies and getting up stream. In some areas the UCB is chaired by a senior director from adult social services and this approach is already showing encouraging signs of having a positive impact on avoiding and minimising emergency admissions. One particular example involves having a qualified nurse who contacts high risk patients following discharge to see if the care plan is working – evidence is emerging that demonstrates this has helped avoid readmissions through A&E.

- Alleviating pressure on A&E: silo approaches still persist and we can be better at taking a whole system approach to these problems. That said, adult social care has invested heavily in intermediate care and reablement services, and many councils now have, or are funding, staff located in A&E departments. There is also room for improvement in developing bed-based hospital avoidance schemes. However, the potential of these is often limited by inconsistent GP and/or consultant cover, as well as a lack of availability of convenient peripatetic clinical testing.

- Optimum allocation of resources: money needs to follow the individual more effectively to incentivise primary and community-based care. This requires a longer-term strategic approach and releasing money from the acute sector. This is not easy and it is not clear where the drivers to make this shift happen will come from (an issue compounded by local pressures to, for example, keep individual hospitals financially sustainable). We want the acute sector to be incentivised to change as part of the process, and to become active partners in shifting resources and activity closer to home.