

**National Children and Adult Services Conference**  
**25 October 2012**  
**Eastbourne**

**Speech by Sarah Pickup, President, ADASS**

Hard Times, Great Expectations

Those of you who are veterans of these conferences may remember that until this year every conference has had a strap line. In 2011 the strap line was Tough times; Good decisions. When we first started planning this year's conference we decided that perhaps there was no need for a strap line. The conference is well established and as the National Children's and Adults Services conference, it pretty much does what it says on the tin. However, as I was preparing to speak to you today and thinking about the current climate it struck me that last year's strap line remains particularly apt.

These are, without doubt, tough times. Tough times for councils balancing rising demand with a freeze on council tax and significant reductions to government grants, tough times for independent and voluntary sector providers of adult social care with both private and state customers facing a squeeze on spending; tough times too for the NHS navigating through major reforms and restructuring while seeking to contain spend to an extent which is unprecedented in the history of the NHS; and of course, tough times for people in need of care and support affected by all of the above and more, as welfare reforms affect some and low interest rates and poor returns on investment hit others. It is also clear that we will not emerge from these tough times anytime soon... The light at the end of the tunnel remains distant and flickering.

So, to return to the strap line, the need for good decisions has never been greater and the extent of reform and of financial constraint means that there are difficult decisions to make at every level, from the individual needing support or their family, to councils, clinical commissioning groups, providers and government.

With the passing of the Health And Social Care Act in June this year and of the Care and support White Paper and draft Bill in July we have a new framework in which many of these decisions will have to be made. There are some key themes through these new frameworks and some new levers and drivers as well as new players and new relationships which we need to draw on and use to good effect to help us through these difficult times and set us on the road to a sustainable future. While frameworks have been set nationally, and national levers and support can assist, the crucial determinant of success as we move forward will be the relationships that are built and the decisions that are made locally.

Here, I would like to pause to reflect on how we might define success and I think that at the simplest level it comes back to what we all want to achieve... We want people to be as healthy and independent as possible, which in turn means that, with respect to health and care, we should be aiming to prevent what is preventable and support people to recover from things where recovery is possible.

Where people do need ongoing support this should be personalised because it is not just the condition; the disease, or the assessed need that should determine the treatment; the response, or the care to be provided but also the character; wishes and circumstances of the person concerned. People who need support also have a view about how they want it to be arranged and delivered. At a recent meeting about integration that I attended organised by National Voices, the preferred definition of what integration looks like from a user or patient perspective was about professionals working together to coordinate care and support around the needs of the individual in accordance with their needs and wishes.

One of the issues we have to overcome is that, despite there being little disagreement about the desired outcome, even in the new framework statutory responsibilities are not framed in this way... Thus it is nobody's statutory responsibility to help people be as healthy and as independent as they can

be. Rather the roles that different organisations have to play are more narrowly defined. What this means is that we will only deliver the outcomes we all seek if we join forces.

The establishment of Health and Wellbeing Boards under the Health and Social Care Act provides a local vehicle for joint decision making. These boards should be well placed to stand back and look at the needs of the local population, to assess the current expenditure on different groups to consider how the needs of particular groups would best be met using all the resources available, in terms of achieving best outcomes and then to look at how to get from the current configuration of spend and services to what is needed.

Integration is likely to form part of the picture given the desire for coordinated care and support for individuals and the impact that spend in one part of a health and social care system can have on another. But integration is a word much bandied around and it is not always apparent what is meant.

There are a number of different areas of work where integration could be considered:

- Commissioning of services,
- Access to services,
- Assessment of need, and
- Delivery of services.

As I have said, from the point of view of the person using services the objective is coordinated care and we must hold onto this as a common purpose - the 'why' when looking at 'what' to integrate and 'how'. We should integrate for better outcomes, reduced cost, improved access, better coordination... Not for the sake of it.

Each of these will have different potential partners... Integrated commissioning is often a partnership between health commissioners and local authorities. Integrated access and assessment may well involve acute and community trusts, local authorities and GPs. Integrated delivery of services could involve the joining of acute and community services in one trust, the creation of multi disciplinary teams between community health providers and councils or could require alignment or integration of independent or voluntary sector delivered social care services with NHS provided nursing and therapy services.

Integration can mean anything from full TUPE transfer of staff from one organisation to another to joint management arrangements or agreements to align services or enable one organisation to directly access services commissioned by another.

What is clear is that, in the current climate we cannot afford to duplicate effort or run parallel systems and that it is a false economy to wait until people's needs are at their greatest before offering support. Both in health and social care the majority of our resources will always be spent on those with the highest needs and we must ensure that these people receive high quality, personalised care and support. However, we will not be able to afford this if we do not do everything we can to reduce the numbers in this high needs group.

The need for an integrated approach starts before we even get to what we think of as a needs assessment. GPs, community health services, public health and social care services need to work together to ensure that we prevent needs arising where that is possible e.g. through identifying people at high risk of acquiring a long term condition and helping them with information, advice and low level support. And then, where people do have an episode of higher needs, offering services that focus on reablement, recovery and rehabilitation.

It is in this area of prevention and recovery that there is probably the most untapped potential to achieve both better outcomes and reduce costs by integration of activity. For example, proper treatment of incontinence and effective action following a stroke can significantly improve people's quality of life and reduce the need for care home admissions and consequent costs to local government. On the

other hand, rapid response home care services and accessible short stay placements can prevent hospital admissions, and the provision of equipment and advice in the home can prevent falls and the consequent costs to the health system.

The issue about separate funding streams is one we need to tackle because, as illustrated above, where a cost falls is not necessarily where a saving lands. What we need to do is stand back and assess what we spend overall on, for example, older people, then consider whether our public pounds are being spent in the best possible way. We need to look at what would best meet needs and then spend accordingly, regardless of funding streams. We have the powers to do this, indeed, under the proposal in the new Bill, and in the health and social care act, we have a duty: but we do not always have the will, the courage or the trust. This is where good decisions are really needed and many of you he today will be members of Health and Wellbeing Boards with the potential to make these good decisions happen.

So we in local government must work better with our NHS colleagues and there will be mutual benefit if we can improve prevention and recovery. This is a necessary but not sufficient condition to managing our way through tough times and minimising the adverse impact on citizens. There are other matters that also demand our attention. Once prevention and recovery have played their part there are still many people who need ongoing care and support and whose needs local authorities have a statutory responsibility to meet. Over 80% of the services used to meet these needs are provided through the private and voluntary sector.

We must turn our attention to these relationships too. The quality of services and the dignity with which people are treated depends on the training and support that care homes and agencies offer their staff, on their recruitment practices and on the way in which their businesses are managed. This in turn is partly, though not wholly, dependent on the way in which such services are procured at a strategic level and used in support plans to help those with eligible needs through personal budgets or direct payments.

When times are tough it is inevitable that local authorities will say that contractors and providers must play their part in achieving savings through improving their efficiency, but too often not enough attention has been paid to the differential impact this will have in different sectors and rather than engage providers in a debate about how efficiencies can be achieved, the blunt instrument of freezing or reducing prices or fees has been used. Up and down the country disputes over fee levels have prevented discussions about how best we can manage with the resources available and how providers might diversify or adapt to ensure the viability of their businesses.

The quality of care that older and disabled people receive is heavily dependent on the workforce employed by independent sector domiciliary care agencies and care homes. As the bodies accountable for ensuring people's needs are met, local authorities must engage better with providers, we must understand what it costs to deliver good quality care, take an interest in the recruitment and retention of the workforce and above all procure services and work with individuals to design support plans that can meet people's needs and respect their dignity.

The responsibility is not all one-sided though... Providers have a responsibility to ensure they can deliver against a service specification for the price they tender including ensuring that they can recruit, train and retain sufficient suitable staff and cover travel costs and time and pay at least the minimum wage.

Because the sad thing is that this industry of care - one of the few growth industries in the country - is more or less a minimum wage industry. The people who care for our most vulnerable citizens can often be tempted away from those roles, however dedicated and caring they are and however rewarding they find their roles in ways other than pay, because the local supermarket offers a better rate of pay. In a small way local authorities can seek to ensure that the price they pay for care allows for a reasonable rate of pay, but this will be in the context of a market where "reasonable" is not far above £6.19 per

hour. Beyond this the value which is placed on care is a national issue and not one which even the best local decisions can resolve.

And so I must come, inevitably, to the question of funding care. As a director of adult social services, trying hard to follow my own advice about prevention and recovery and about integration and working with providers; and in an authority where members do provide for demographic pressures and are willing to properly consider pressure on providers, I still feel that care services are "on the edge".

Pressures on council budgets mean a squeeze on prices and allocation of personal budgets which will be sufficient to meet eligible needs and no more. This in turn means a squeeze on providers as they try to compensate for frozen or lower prices and sometimes to deliver care in visits that are too short. The loser, of course, is the person who we all say should be at the centre of what we do.

In the recent care and support White Paper the Government set out a compelling vision for the future, one which encompasses prevention and recovery, promotes integration where this will deliver better outcomes, provides new rights for carers and greater equality of access as well as more personalised care for people who need ongoing support. It is likely to be true that we can deliver some of this vision by making better use of our public pounds if we can make good decisions locally but this is a system in crisis...

Even before the current period of austerity it was widely acknowledged that adult social care was underfunded. Since then we have taken £1.89bn in savings from adult social care budgets. There is wide discussion about the recommendations of the Dilnot Commission. ADASS has supported these recommendations as providing a solution to the problem of the random and uninsurable distribution of catastrophic care costs. But these proposals if implemented will not deliver additional resources into our cash strapped system. So the second funding question that sit alongside the Dilnot question is how much will it cost to deliver the kind of care system set out in the White Paper and how will this be funded? This question needs an answer and getting to an answer will require an honest appraisal of the costs of different types of care. On this we need a good decision at national level.

In conclusion, I think we can say that national Government is relying on local government and its partners to take good decisions to drive forward its vision. Local government and its partners for their part are relying on national government to take a good decision about how to fund it.

To add a Dickensian touch to our former strap line:  
These are Hard Times and there are Great Expectations!