directors of adass adult social services
www.adass.org.uk

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FUTURES

The cruellest month?

Austerity hits home

Sandie Keene

From chemistry to social care

Comment

Compassion, Candour, Culture… and Cake!

NONE OF US can have failed to have been shaken by the witness testimonies in the original Francis report, or to have paused to reflect again, upon seeing the public inquiry report a couple of weeks ago *(See Peter Hay and Jon Rouse, Pages 20 - 23)*.

It won't only be me, I know, who feels a sense of real unease that negative attitudes towards older people will have had at least a part to play. Where the context is a culture of not truly listening to the needs of older people, combined with a setting more focused on illness than identity, the risks must be increased.

The struggle to understand how appalling treatment can remain undetected is hard to absorb whatever the setting. Not that abuse is confined to the vulnerable by virtue of age of course – as Winterbourne View revealed.

Compassion must surely lie at the heart of minimising the risk of neglect, or worse. A compassion which is not simply 'icing on the cake' but something fundamental which should characterise and help to shape services around people's needs. Issues of good nutrition, hydration and care and support, personal hygiene are all matters of importance equally across health and social care.

Eight million people in the UK now and half of those born after 2007 can expect to live to a hundred. By 2030 the number of people aged 65-plus will increase by 51 per cent and the number of people aged 85-plus will double. The rise of the over-65s with chronic diseases is set to increase by up to 50 per cent. Major social change of this order is hard to contemplate but will lead to, and require, huge changes in family and community support and in the health and social care support systems in the future.

Post-Francis and Winterbourne View, the challenges of learning from what went wrong must exercise us all if we are to strive to minimise the risk of recurrence. Albert Einstein said "intellectuals solve problems, geniuses prevent them." Thankfully, we know the importance of our focus on creating a positive culture that doesn't tolerate poor standards, only focuses on compliance measurements which positively affects residents and has values based on respect for each other. We know too that the setting of the culture starts at the top and that it's a huge leadership challenge to focus on the right priorities.

Good quality assurance systems covering internal professional challenge; strong commissioning of external providers; independent challenge, and strong use of the user/carer voice need to be well-balanced across these domains, but with the resident's view and outcomes at their heart. A healthy culture recognises that openness and dialogue are essential for service improvement; that an open environment where candour is welcomed and where behaviour accords with professional standards are the best ingredients for safe and high quality care. Francis, remember, spoke of a focus on targets, systems, processes and money as being part of the problem.

Before visiting a home for previously homeless old people in Kerala in southern India recently I was told that a small gesture upon visiting would be to take some cake. This was greeted with some delight; the warmth and happiness of residents and staff, despite quite basic facilities, were simply overwhelming.

Compassion shone out from the cook, the carer and the manager. Compassion costs nothing but transforms people's lives and experiences of care. It takes good judgement and commitment, not genius, to be continually assuring and improving the quality of services and to be safeguarding high standards of care by creating an environment where excellence in social care can flourish. Leadership throughout the system needs to involve service users, carers, professionals and partners in shaping and designing a new social care offer for the future. Yes it's all about the culture. But if the key ingredient is having compassion at its heart then the Francis focus on a new duty of candour would become less critical. Cake however: now that's a different story…

Linda Sanders
Vice President, ADASS

In this issue

ADASS seeks to keep CSR savings at a minimum

THE ASSOCIATION IS gearing itself to contribute significantly to the current spending review which has been commenced by the Treasury. The complexities have been compounded by the Chancellor's surprise decision to bring Dilnot implementation forward by 12 months, and to re-set the cap at £72,000 – an announcement he made days before this year's Budget statement in March.

According to ADASS President Sarah Pickup, the current spending round "is one of the toughest, and most important, that the Association has ever engaged with. Never before have our social care budgets been so stretched nor the ingenuity of our management systems so under pressure. Everyone is expecting local authorities' finance to be targeted again. It will be up to us to ensure that, while accepting the need to maximise efficiencies, frontline services for older and vulnerable people are protected as far as is humanly possible."

The annual ADASS budget survey, which is due for publication shortly, will figure highly both in the ADASS submission to the DH, and in the DH's submission to the Treasury.

In an article in *Futures,* Resources Network Chair John Jackson, who has been closely involved in the CSR discussions, writes: "Adult social care has had to make savings of seven per cent in each of the last two years (a total of £1.89 billion) because local government as a whole has had to make savings of that magnitude…

"The fact that here is scope for each of us to make some savings is not an argument that we can carry on making seven per cent savings a year like we have done over the last two years. We have considered carefully what would be a challenging but realistic assumption going forward. We think that the maximum that can be safely assumed is three per cent a year."

Sarah Pickup

(See All eyes on June P 25)

TWO ASSISTANT DIRECTORS have been chosen to co-chair two of the Association's policy networks following a decision by the ADASS executive council - a decision which itself follows on from the extension of the membership to non-chief officers from last April.

Mark Godfrey, AD in Coventry has been appointed as the new joint lead for the physical disabilities, HIV and sensory impairment network after being nominated by John Nawrockyi, RB Greenwich and seconded by Linda Sanders LB Hillingdon. The position becomes vacant as Linda takes up her duties as vice-president.

Mark Godfrey

Meanwhile Lucy Butler, AD Oxfordshire, has also been appointed as the new joint lead for the mental health network after spending many years as its secretary. Lucy was nominated by Terry Dafter, Stockport, and seconded by John Jackson, Oxfordshire.

ADASS Honorary secretary Richard Webb said "we would all like to thank Linda Sanders and Stephanie Butterworth for their hard work and commitment to leading these networks. We are delighted that Mark and Lucy will be taking on the roles of joint lead to take forward these vital areas of work."

Linda Sanders becomes the Association's vice president at the AGM this month, as Sandie Keene becomes the new president.

Sandie Keene

WELCOME AGAIN TO...

COVENTRY, AND TO this year's annual spring seminar which, like last year, is being held at Warwick University. Two more big welcomes too: to the many assistant directors and non-chief officers who, as a consequence of a decision taken here at last year's AGM, are now part of a wider membership and wider ADASS family.

That was an important decision in the Association's history and it points to a future where we shall have wider influence, be more widely influenced ourselves, and where the range and depth of our policy input into national issues will be substantially enhanced. Three of our well-established new members, Lucy Butler, Mark Godfrey and Matt Bowsher, give their views of ADASS on pp 28/29.

Our other welcome goes to Chiamaka Iwunze, our graduate trainee from the National Skills Academy who has so successfully taken up from where Lizzie Comley left off earlier this year. Lizzie has moved to the London Joint Improvement Programme, and our best wishes go to her as much as our best welcome goes to Chi. Read more about her on page 9.

This year, as last, we welcome some of the key figures in social care talking about the key issues that confront us all. We are especially pleased that the Care Minister Norman Lamb is coming to talk to us, and that there will be strong representation from the CQC And other of our co-stakeholders in the social care sector.

A special thankyou, too, to Mary Gillingham and her colleagues in the Business Unit who have worked so hard to make this seminar the inspiring, stimulating event I know that it is going to be. Enjoy the content, enjoy the networking and the social activities and, above all, take the lessons learned back to your authorities for their benefit as well.

Richard Webb
Honorary Secretary, ADASS

Society's report a `worrying blight' on care efforts - ADASS

A RECENT ALZHEIMER'S Society report* acted as a `timely reminder' that there is no excuse for failing to protect people with dementia in care homes, according to ADASS.

The report showed that 80% of care home residents have dementia or severe memory problems – much higher than previously thought – and that although excellent quality care exists, pessimism about life in care homes is leading to people settling for less.

Three quarters of relatives would recommend their loved one's care home despite less than half saying their relative has a good quality of life.

It also revealed the care home sector has a real image problem. According to a YouGov 70 per cent of the general public would be worried about going into a care home and two thirds (64 per cent%) don't think the sector is doing enough to tackle abuse.

According to ADASS President Sarah Pickup, directors of adult social services are doing all they can to work with partners in the private care sector and the NHS to promote effective ways of communicating with, supporting and caring for people with dementia and their families and carers whether living at home or in care homes.

Also, ADASS is working with regulators to explore ways in which older people – especially those with dementia - and their families and carers can be reassured that care is being provided to the highest standards possible. She said: "the probable re-emergence of some kite-marking of care homes, currently under discussion, will be an important way of helping families and their loved ones understand, compare and assess providers more easily."

She said ADASS is `seriously concerned' at the survey's finding which suggests that older people are increasingly apprehensive at the prospect of entering a care environment. "We, and our colleagues in the health and other services, exist for no reason other than to care for people, not to scare them. It is a worrying blight on our efforts if a growing number of people are scared of what we provide. We must all, throughout the social care sector, seek to ensure that the high standards of security and happiness experienced by the vast majority of people in care homes is better portrayed and communicated." *(See Where there's a widget Page 19)*

Low expectations: attitudes on choice, care and community for people with dementia in care homes Alzheimer's Society 2013

Plan to push PBs for people with mental health issues

LEADERS OF TWO major professions in England have come together to pledge to work in a closer, more integrated way for the benefit of people with mental health problems.

ADASS and the Royal College of Psychiatrists have agreed to help the recovery of people with mental health problems through personalisation and will support the use of Personal Budgets in social care and Personal Health Budgets in the NHS.

In a joint protocol issued recently, negotiated by Terry Dafter and Lucy Butler from the Mental Health, Drugs and Alcohol Network, both organisations have committed to working together to develop and widen access to integrated individual budgets by building on the Department of Health's national Personal Health Budget pilots which ran from 2009 to 2012.

These found that "…[they] are cost effective for mental health. They improve people's health-related quality of life and psychological wellbeing compared to traditional service delivery and reduce indirect NHS costs."

They go further in calling for integration between health and social care budgets as many individuals with mental health problems receive services from both the NHS and social care. In their joint statement they said "everyone who chooses to have a Personal Budget and a Personal Health Budget should have the right to have an integrated assessment across the NHS and social care."

They also argue that by tackling unnecessary bureaucracy and a lack of information-sharing between clinical staff, both organisations are also committed to increasing the low take-up of Personal Budgets for individuals with mental health problems. "In 2010-11, only 9 per cent of adults with mental health problems who were eligible for a Personal Budget received one compared to 41 per cent of adults with a learning disability."

Terry Dafter

Update on Winterbourne View

Andrea Pope-Smith

FOLLOWING PUBLICATION OF the Concordat, the improvement programme is now being jointly led by the Local Government Association and the National Commissioning Board, with Chris Bull appointed as the programme lead. It currently meets monthly, with ADASS being represented by ADASS learning disability lead Andrea Pope-Smith. People who use services and family carers are also represented on the board.

Every two weeks there is a teleconference between Chris Bull, DH, NCB, LGA representatives and Andrea to identify any issues and check progress. A project team to monitor and lead the implementation of the improvements is being set up, funded through the DH monies highlighted in their report. The team will be made up of a wide range of policy, analytical and specialist expertise and will provide updates and progress reports once it is established

ADASS has published a temporary secondment in the first instance, to the Project Team. It is hoped that we will then be able secure ongoing involvement with the Project Team representing Adult Social Care. Andrea has agreed to provide support to the successful applicant. Meanwhile Honorary secretary Richard Webb has volunteered to support Andrea to ensure we are able to cover the range of developments emerging from this programme.

According to Andrea Pope-Smith, a number of issues on the horizon include:

All age - children and adults - joint commissioning arrangements/current provision and placements/improvement plans including plans to develop community-based models of care and support. Visibility of joint plans at learning disability partnership boards (LDPB) and health and wellbeing Boards (HWBB) is important.

Key questions have been produced and are on the ADASS Web Site. These need to be used to shape and improve visibility, awareness and understanding across LDPB's, HWBBs and Safeguarding Adults Boards in your localities.

A letter went out from the NCB to NHS Commissioners in January about the reviews of people in hospital and treatment and assessment settings. At this stage the emphasis is on NHS commissioners. Following further discussion a revised approach will go out targeted at joint health and social care commissioners. This will come out with a clear and brief guidance framework.

According to Andrea: "It is important to understand what activity has already taken place in your region/locality. I would advise you to raise with your local CCG and regionally with either the residual SHA and/or NCB. Once the guidance is available it will require joint local agreements and activity to deliver effectively.

"The guidance will also set out the need to signpost good quality independent advocacy for people who use services and the potential for commissioners to arrange for independent citizen advocacy organisations to undertake random samples of reviews already completed."

Francis: Rouse pulls no punches

Jon Rouse

JON ROUSE HAS been appointed director general of social care, local government and care partnerships at the Department of Health earlier this year, replacing former ADASS President David Behan who moved to become chief executive of the CQC.

Formerly chief executive of the Housing Corporation, he was previously chief executive of the Commission for Architecture and the Built Environment (CABE). Prior to that Jon was secretary to the Urban Task Force and policy and communications manager at English Partnerships.

He spent five years at the Department of the Environment, including a spell as a private secretary to the Minister for Housing and Local Government. His most recent post before moving to the DH was chief executive of Croydon Council, a borough he joined in July 2007.

In an article in this issue of *ADASS Futures* Jon writes in some depth about the problems thrown up by the Francis Report into Mid-Staffs: particularly issues surrounding leadership and safeguarding.

He writes: "The report has hard-hitting messages and recommendations on a range of relevant issues, including commissioning, community voice, staffing levels, whistleblowing and leadership, that we must engage with fully in respect of the required response of the social care sector."

(See Opportunities knock, Page 22).

Sharpening users' teeth

Anna Bradley is the Chair of Healthwatch England, the new champion for consumers and users of health and social care services. She talks to us here about the organisation and her vision for the recently launched Healthwatch network.

WHAT IS HEALTHWATCH ENGLAND'S ROLE AND HOW DID IT COME ABOUT?

The Health and Social Care Act 2012 established Healthwatch England as the champion for consumers and users of health and care services. Healthwatch England will give a national voice to the key issues that affect children, young people and adults who use health and social care services. It will develop an overall view of trends and consumer experiences at a national level based on evidence, strongly informed by local Healthwatch. This is the first time a national champion has been set up with independent statutory powers to act outside of Government influence for both adults and children.

HOW DOES HEALTHWATCH ENGLAND WORK WITH LOCAL HEALTHWATCH?

The network is made up of Healthwatch England, which is nationally-focused, leading 152 community-focused local Healthwatch. Together we form the Healthwatch network, working closely to ensure consumers' views are represented both locally and nationally.

Healthwatch England has an important role to lead and support the development of local Healthwatch. Local Healthwatch will focus on local voices being able to influence the delivery and design of local services - whether it's improving them today or helping to shape them for tomorrow.

Healthwatch England will use their evidence to make sure those who plan, run and regulate care services understand what matters most to consumers overall.

HOW CAN HEALTHWATCH WORK WITH ADASS?

An important element of our planning is finding out what others in the field of consumer and user advocacy know about the issue and what they are doing. Healthwatch does not have a monopoly of wisdom on consumers and users of health and social care. We are keen to avoid reinventing the wheel as there is simply too much to do.

Organisations such as ADASS have many years worth of specialist knowledge and experiences and we are keen to tap into that to capture the necessary evidence to represent the consumer's voice. We have had over 130 third sector organisations, large and small, national and local, pledge their support to the Healthwatch network which is really good news. As a collective we can make more of a difference.

WHAT MAKES HEALTHWATCH DIFFERENT FROM THE VARIOUS VERSIONS OF LOCAL PATIENT AND PUBLIC ENGAGEMENT TO DATE?

The Healthwatch network is being established to fill a gap in the health and social care infrastructure and will replace the outgoing Local Involvement Networks. Healthwatch is different in significant ways. We have renewed and enhanced statutory powers covering adult and children's health and social care:

- Local HealthWatch have a seat at Health and Wellbeing Boards for the first time,
- Healthwatch England reports to Parliament and has a statutory right to be consulted on key decisions,
- We can all call on local and national bodies to take action and those bodies must respond, even if they don't agree,
- We will use our position, our evidence and our powers to influence change in a variety of ways with a focus on change that will benefit consumers and users of health and social care.

WHAT IS YOUR VISION FOR THE HEALTHWATCH NETWORK?

I believe we all want to see consumers and users of services, their families and carers, involved in designing and delivering services needed by local communities. And I believe we all want to see services shaped around the people who need them, rather than requiring people to fit themselves into service-shaped packages. We are here to champion consumers and users and ensure their needs and views are listened to at national and local levels.

Whether it's the Clinical Commissioning Groups, NHS Commissioning Board, the Care Quality Commission or indeed the Secretary of State, Healthwatch will be the constant reminder that engaging people in their care, its planning and delivery is a necessity, not a tick box exercise.

WHAT'S AHEAD FOR HEALTHWATCH?

I am confident we can make a massive difference and for the first time make sure consumers and users have real teeth. It is their insight and experience that can help us all make sure the care we deliver is the right care in the right way at the right time. A vision we all share and an opportunity I relish.

Find out more about Healthwatch England at www.healthwatch.co.uk

A seamless flow of info…

Terry Dafter

THERE HAVE BEEN many national, regional and local initiatives to improve care information and purchasing options through the power of the internet over the last couple of years. Many of these overlap. Some have taken significant LA investment by directors. None has yet achieved a critical mass of public usage and provider sign-up.

There will be public benefit in assessing the value of different approaches and where they are complementary or duplicating effort by individual LAs. This is one strand of the Web of Support programme that the Information Management Group of ADASS is commencing with DH funding.

The public website strand will look at advice and guidance sites including SCIE's FindMeGoodCare, charities and some LAs. It will consider resource directories and feedback sites such as Yorkshire and Humber's, NHS Choices and Care Opinion. It will include a survey of e-marketplaces/commissioning tools such as the West London Alliance's CarePlace and Bromley's MyLife. It will cover applications offering online self-assessment and access to care records. The outcome will inform what use LAs make of the £32.5 million being made available by DH from April next year to improve the transactionality of publicly funded social care websites.

ADASS IMG has a vision for the future of adult social care information systems to reflect personalisation and the reducing role and resources of local government. The Web of Support vision was presented at last September's conference addressed by Norman Lamb. It envisages a world of seamless sharing of relevant information between the different organisations delivering social care – all focused around the individual and under their control and consent (or that of their carer or other proxy, which might even be the social worker).

This vision needs fleshing out and some detailed work completing to support

ADASS IMG has a vision for the future of adult social care

a business case so that LAs can play their part in making it an operational reality. One example we will be building on is the use of secure email for communications between hospitals and social care departments as being established across London - not leading edge technology but bringing practical benefits to practitioners and citizens.

We will also look at how newer technologies than the old monolithic case management systems might improve the efficiency of the inhouse care workforce – including Bring your Own Device – always remembering the sensitivity of information we deal with and the need for us to account for activity and expenditures while optimizing outcomes.

We will also be taking account of any recommendations arising out of Dame Caldicott's review of information governance and client confidentiality.

Finally, all directors will be aware of the potential administrative implications around the implementation of the new funding arrangements and the cap on individual care costs. We are engaging early with the information requirements to ensure that these can be dealt with as efficiently as possible in the medium to long term.

The programme is ambitious with a modest budget. It offers us the opportunity to influence and guide some of the national work developing across DH and the NHS Commissioning Board and I ask fellow directors to support our initiative. A first step will be to invigorate the regional network of IMG groups and have them work appropriately with colleagues in performance and commissioning.

We have good, effective networks in some regions but poor in others and please ensure that you have a nominated responsible officer joined to the networks. We are confident that we will be adding capacity and support for those officers, not distracting them from their day-to-day responsibilities. As electronic transactions become increasingly commonplace, we cannot afford for social care to miss out, and given the network of organisations providing social care we will need to adopt collaborative and co-production models.

Terry Dafter
Chair, ADASS Information Management Group

Extending the membership

AT THE AGM in April it will be a year since the decision was taken to expand the ADASS membership, writes *Mary Gillingham*. Every DASS can now nominate up to four members of their senior management team with responsibility for adult social care to become members of ADASS. To date 137 authorities have taken up the offer and we now have 393 extended members, some of whom we are welcoming to the Spring Seminar this year for the first time.

There has been longstanding involvement by extended members in the work of the policy networks but the new arrangements enable closer connection and new opportunities. At the time of writing, elections are being held for some of the vacant roles for joint chairs of the policy networks and several of those standing are extended members. More broadly the ADASS occasional seminars are open to the whole membership and receiving the weekly bulletin will keep everyone in the loop on policy developments and the positions that ADASS takes in the media, as they emerge. The association is much strengthened by this initiative and we look forward to consolidating the gains.

There is an upward trend in the number of authorities bringing together the DASS and DCS roles. At the last count it was nearing a third of the membership. This emphasises the pivotal position of the annual NCAS conference held in the autumn, as the national forum for consideration of adults and children's issues.

We are pleased to have successfully completed Lizzie Comley's year long placement as a graduate trainee from the National Skills Academy scheme. We are now delighted to have with us Chiamaka Iwunze *(See profile opposite)* as our second trainee. We are able to offer a unique national overview and benefit hugely from the developing skills, enthusiasm and ideas which they bring. Jonathan Gardam has been very committed to ensuring their experience is comprehensive, as their placement supervisor.

On the policy front we are currently out with the annual budget survey. The return rate for this is always impressively high and in the context of preparations for the spending review, is as important as ever this year. It has huge credibility as it confirms the aggregated position across authorities and there is always considerable interest in the key messages. Also in train is a new survey running jointly with NHS Confederation to find out how people are approaching integration in practice. There are a range of different proposals being implemented across the country. The results from the survey will help to establish some baselines and will be a contribution towards demonstrating what works – sector led improvement in practice. Among other recent important inputs have been Sarah Pickup's oral evidence to the Health Select Committee on the Draft Bill, feedback to the Nuffield Trust on the health and social care ratings review and currently underway, a response to the Department of Health consultation on market oversight.

The policy event for the executive council in January set out the key themes for the coming year. These will form the main plank of the business plan 2013-14 and include: submission to the CSR, integration, commissioning (market development and leadership), early intervention and prevention, social impact bonds, quality and sector led improvement.

We look forward to supporting the President's team as these work streams develop over the next year.

Mary Gillingham
Business Manager, ADASS

Comings and Goings

September 2012 – March 2013

New DASSs

Hounslow – **Sherry Malike**
CLB Camden – **Rosemary Westbrook**
Hull CC – **John Readman**
LB Southwark – **Romi Bowen**
Wakefield – **Jim Crook**
Dorset – **Dr. Catherine Driscoll**
Trafford – **Deborah Brownlee**
Shropshire – **Stephen Chandler**
Warrington – **Steve Reddy**
LB Barnet – **Dawn Wakeling**
West Berkshire – **Rachel Wardell**
Wiltshire – **Maggie Rae**
LB Harrow – **Bernie Flaherty**
Wigan – **Stuart Cowley**
City of London – **Ade Adetosoye**
Northampton – **Carolyn Kus**

DASSs who have left

Judith Petterson – **Ex LB Hounslow**
Susanna White – **Ex LB Southwark**
Sam Pratheepan – **Ex Wakefield**
Debbie Ward – **Ex Dorset**
Nick Hudson – **Ex Wigan**
Lorna Payne – **Ex Havering**
Charlie MacNally – **Ex Northampton**
Joe Blott – **Ex Warrington**

Movers

Joy Hollister - **moved from City of London to LB Havering**
Paul Najsarek – **changed from DASS to Extended Member at LB Harrow**
Angela Dunn – **changed from DASS to Extended member at Hull CC**
Kate Kennally – **changed from DASS to Extended member at LB Barnet**
Ian Curryer – **changed from DASS to Extended member at Nottingham City Council**
John Bolton – **suspended Associate membership to become interim DASS at Walsall**

Associates

Sue Redmond – Ex Wiltshire
Carol Tozer – Ex Cornwall

Associates Cancellations

Colin Foster

DASSs' contact details available at www.adass.org.uk/index.php?option=com_content&view=article&id=180&Itemid=161

A challenging year in store...

Chiamaka Iwunze

CHIAMAKA IWUNZE STARTED her year as a National Skills Academy graduate trainee with ADASS back in January, following on the heels of her predecessor Lizzie Comley with whom she maintains close contact. The second trainee to work with the Association, Chiamaka, Chi - pronounced `Chee' - as she is known to friends and colleagues, had been working for the NHS in Manchester. Her brief encounter with some youth work in Manchester made her re-think the area in which she wanted to work.

Born 27 years ago in Lagos, Nigeria, (she doesn't like being 27 – "it's odd," she explains, mysteriously…) Chi is the youngest child of Meg and Livy Iwunze. Her father was a renowned Nigerian journalist who wrote for the *Nigerian Punch,* the *Nigerian Guardian, Champion Newspaper* and edited the *Nigerian Economist.* He died five years ago, but she still has her mother – a businesswoman now – and an older brother and sister all living in Nigeria.

She studied Pharmacy at the University of Lagos where she left with a 2:1 and went on to study for her Pre-Registration Certificate at Lagos University Teaching Hospital (LUTH). That took a year, but once licensed she was able to move and take over as chief pharmacist at a private hospital in the same city.

After nine months there, her Uncle Leo-Stan Ekeh fulfilled her dreams by providing the finances for her studies in the UK to take up a Masters at the Manchester Business School studying health care management for a year during 2010/11.

Chi, who is proactive, did some part-time work for some UK work experience; she worked first as a census collector for the Office of National Statistics, then for the company that processed the census forms. When she finished the MSc she went on to work for the Royal Bank of Scotland as a customer services adviser before deciding to take a bit of a break: "I felt I'd been working for so long I needed a rest!" she says.

So she did a brief tour of the UK, staying with friends and family in London, Leeds and Sheffield: "I come from a small nuclear family, but a large extended family." It was following that respite that she found herself drawn more to human rather than pharmaceutical challenges, when she spent a month working for Manchester City Council in their Youth Offending Team.

"It was only for a short month," she says, "but it was extremely intensive and made me begin to think that I might, after all, do something more in social care. Basically I was working in a unit looking after under-18 year old offenders, helping them to avoid re-offending. It involved working with Connexions and alcohol and drug abuse units to help these youngsters get back on track.

"Working as a support worker and administrator I had no direct, formal contact with the children. But on reception I had plenty of opportunity to talk informally with them, learning that it's the way you treat and deal with them – not simply treating them as bad people – that encouraged them back for more sessions in order, finally, to get their discharge and go back to face the real world. We helped them find jobs and all sorts of things…

"It was very emotional for me, going through their case files. A lot of them were abused; a lot from care homes. You could see their stories and the way they were treated in those homes. It's why some of them went missing or joined gangs…

Still impressed by these experiences, she joined the NHS Manchester PCT in February last year working with the Manchester Integrated Care Gateway, helping patients choose the right hospital and managing the appointments. Her office could cope with anything up to 600 referrals a day – very busy, but, she says, she enjoyed and learned a great deal from the experience she gained working with patients.

But, still enthused by her previous work with young people, when the opportunity to join the National Skills Academy arose, she took it. It was her boy friend, Nigerian but, like her, UK-based, who sent her link to the advert "because he knew I was interested in local government." She applied, and acknowledges the `challenging' nature of the application process, and impressed, still, with the speed that decisions were made once the exhaustive and exhausting interview process was completed.

She admits she was `overjoyed' when she was chosen, but reflects ruefully on the final assessment: "nobody showed any expressions at all, so I simply didn't know if I was doing well, or doing badly: I was really scared," she laughs. She was on holiday in Nigeria when she got this amazing news on Christmas Eve (her last day on holiday), and immediately started to make plans to move down to London.

Early thoughts of being with ADASS? "I wouldn't say it hasn't been challenging," she smiles, but admits she'd been to places – Parliament in particular has impressed her – she'd never dreamed she'd visit, and met people – Ministers and peers – whom she'd never dreamed she'd meet. Only three weeks into the scheme when interviewed she says "it's been very exciting, with so much going on in the sector. But gradually everything is beginning to get connected, and make sense. I'm just happy to be here and to learn as much as possible." For the future? She's interested in how care homes are actually managed; how councils work, how commissioning and integration are done. In the long term she'd love to be involved in commissioning and policy development.

Special interests? Hobbies? Pastimes or sports? Well, she loved acting at school, but hasn't been on a stage since. But "I love reading/watching detective series, and go to the gym fairly frequently." But shopping, writing, fashion, travelling and meeting new people are her big loves. She'll certainly have had her full of the latter by the time her ADASS year is ended….

From chemistry to social care

Sandie Keene

Is it a contradiction, or perfect symmetry? Probably somewhere in between these opposites you'll find the explanation of why the Association's incoming President, Sandie Keene, emerged from a comfortable Northern family of successful industrialists, a boarding school in East Anglia and a degree in chemistry to become a committed and passionate leader of social workers and social services, *writes Drew Clode.*

Born in Sheffield in 1954, she grew up the youngest of three children in a family environment dominated by business. A happy childhood? Yes, but she went away to school, Felixstowe College in Suffolk, at the age of ten and although happy, recognised, "it doesn't do a lot for family life, especially when it isn't part of a deeper family tradition which, in our case, it wasn't. We were a family who met in the holidays, and in many ways became quite fragmented," she says.

The fragmentation was worsened when her father died suddenly and unexpectedly shortly after her return to Sheffield to study at University. His company had been severely affected by the 1970s recession, an experience which alerted her forever to the fragility of financial circumstances. She'd been particularly close to him: "I used to go back to Sheffield during school holidays and work for him – I loved it there, loved getting to know the people he worked with, and totally loved that business environment."

So why the transfer from science to social care? "If my father had lived I would probably have become an accountant," she thinks. The answers are as simple as only extremely complicated answers can be: even before going to University she had become deeply entwined in matters of church and faith – a commitment which is ongoing.

She is very matter-of-fact about it, and proud to be a member of a 1,000-strong church community with strong commitments to working for social action with asylum seekers, detached youth work, recovering addicts, maintaining a food bank and other outreach activities. She was learning that despite her background and education, she was far more engaged in issues surrounding human relationships than in the colder realities of chemicals, molecular structures and periodic tables.

"I became disenchanted with science at university: all the lecturers and professors just loved their test tubes. But I wasn't particularly bothered about that at all." So, just before graduation she wrote to all her nearby local authorities and said she wanted to learn a bit more about social work. Barnsley replied offering her an interview, though "I didn't know that I was being interviewed for a job as a trainee social worker."

Notwithstanding, she was offered a job as a trainee and never looked back: "I kind of fell into it really … It was totally life changing." Even more so when you recall that she ended up working in one of the most deprived areas of South Yorkshire. "It was amazing. But I absolutely loved it and ultimately went back to Sheffield Poly to study for my CQSW – then the main postgraduate qualification for the profession."

She stayed in Barnsley for 12 years (1974-86), ending up as a team manager, but by that time feeling distinctly unchallenged. So when a job came up in Rotherham for one of the first breeds of child protection co-ordinators, she jumped at it. Created around the time of the Cleveland Inquiry, local authorities were waking up to the fact that they had to take child protection seriously.

She loved Rotherham. It's where she began to develop her management and leadership skills, particularly inspired by the then director, Pat Nolan: "What a character he was - one of the first directors appointed without a social work qualification! I remember people wondering how he could ever do the job. It's not at all unusual these days and he quickly proved that a strong value base and visionary leadership were the prerequisites for establishing excellence."

Sandie was part of a small team of policy officers comprising colleagues from health, child care, child protection, mental health and learning difficulties. Within a couple of years she became head of the policy unit and embarked on managing the inspection unit ("such as it was then, with its two members of staff!") before suddenly having to confront the realities of the late-1980s community care legislation. "Again, Pat Nolan was committed to Rotherham being ahead of the game."

So Sandie was appointed as the lead to develop all the change management for the community care legislation. "My small team did all the preparations for contracting with independent providers, developing micro enterprises with innovative use of community care funding, quality inspection and partnership with the Health Service (it sounds a familiar agenda for today!)." The upshot was that she was appointed assistant director for policy in Rotherham in 1992 and then, in 1996 following a departmental restructuring, she became head of adults with operational responsibility for commissioning and provision.

Three years later she became deputy director in Sheffield, a post she'd been attracted to because of her commitment to continuous improvement. At that time it had just gone into special measures. Director Martin Manby had only recently left and chief executive Bob Kerslake (who was to rise to become current head of the civil service) had just appointed Penny Thompson (now chief executive in Brighton) as the new director. The deputy's role was to follow through on the improvement agenda and get the city back onto its feet.

Careers as well as life can turn full circle. Within two years of her appointment Sheffield, too, restructured and Sandie once again took on the role of head of adult services. Her career in Sheffield became a replica of that in Rotherham, working in an environment that was "incredibly stimulating – incredibly hard work." Today Penny takes a place, along with Sandie's current chief executive Tom Riordan, on the list of outstanding leaders from whom she has learned and taken strength and support.

Sandie's first director's post was in Barnsley which she joined in 2004 as director of social services. When the authority finally, reluctantly, split the two services and it was clear that the then head of children's services would get the DCS post, Sandie was left thinking "am I going to be busy enough…?" She laughs in hindsight, a laugh laced with irony. She took up her present post – director of adult social services in Leeds - in 2007.

We need a conversation which focuses on assets and strengths

As she enters her ADASS presidential year she is totally aware of the colossal changes which have overcome social care services in the past 30 years, and the colossal challenges facing them now. But despite the current financial climate she believes "we are in a far better place now than we were in the 1970s. It's just beyond recognition." She goes on: "I was reminding colleagues not long ago that when I first came across adult social care, people's only options were two hours home care in a week, and if you were lucky – this was a mining community – you could probably get fire-lighting five times a week. But we had to beg, borrow or steal support from neighbours, family and community to get it done at weekends!

"And the alternative to that was residential care. Those were the days when people with learning disabilities and older people with more complex needs were still cared for in hospital. Personalisation was a distant dream.

"But we cannot be complacent and must strive for yet more development and progress. There are still people failing to achieve the potential they aspire to and the quality of care remains too variable. The financial and demographic challenge is not going to go away and no one person or organisation is going to come up with the single solution on their own."

Sandie welcomes the announcement of support for the Dilnot recommendations but is all too acutely aware that it is only the first part of the funding requirement. The important next step is the contribution to the current spending review debate and establishment of the business plan for adult social care funding in the long term. In the meantime, the sector is looking to maximise every element of creative activity to enable needs to be met, budgets to stretch and quality to improve.

At the heart of this activity, Sandie believes, should be a new conversation with the public about individual and collective contributions to the solution. She says: "we need a conversation which focuses on assets and strengths rather than problems and needs, a conversation which recognises that every individual has aspirations and the capability to contribute to the wider community. The question for assessment is 'what can you contribute and how can we help you?' and not 'what can't you do and what can we do for you?'"

By opening up this different kind of dialogue, Sandie believes, we could create a pivotal shift in the way we coordinate and commission care with partners. The encouragement of enterprise, community engagement, volunteering, time banking, corporate social responsibility in business, commerce, industry, in fact every part of our society, builds on and strengthens the assets that exist in communities.

The exploration of new funding mechanisms through social impact bonds, reinvesting the community's own capital back into local people has, for Sandie, a strong potential for the future. She describes Leeds's aspiration for building community social work back into the hearts of localities. In this model, social care and health colleagues are creating integrated care pathways focused on GP populations, predicting risk and encouraging self-care, with fully integrated care records owned by citizens.

"There is little doubt that partnerships and integration will be the feature of the next year", she says. "Initiating new partnerships and developing the old ones will be crucial as we go forward. The opportunity for partnership with existing providers, founded on a mutual commitment to improving quality based on service user experience, has the welcome potential to take the discussion beyond the issue of fees. The development of micro enterprise and alternative models of social care delivery, through cooperatives, mutuals and individual personal assistants are also being consolidated as the provider landscape for the sector."

The new commissioning environment in health offers enormous opportunities, but also huge threats. As ever it is likely to be the quality of local relationships which offsets the natural turbulence of change. She is keen to promote the collective endeavour required to make the difference in health and wellbeing, where colleagues in health and social care work together to ensure the future is better, simpler and more cost effective. But the jury is out, for now. How effectively will the new architecture develop over time? And how will the potential for fragmentation be avoided?

Sandie continues: "if you think now of the range of choices available to people - yes, we know that it isn't all that it needs to be, and it needs to be more - it is substantially different from how it used to be. And long may that continue! For the people we serve, for our organisations and for me, it is all about helping people realise their potential. The opportunities for this, through personalisation, are so much greater than they were."

Sandie first became a member of the Association when it was still the ADSS and its members had responsibilities for child as well as adult care. And it was in the organisation's branch structure – as in so many other cases – where she felt its most immediate and beneficial impact. It wasn't long, in fact, before she became secretary and then chair of the Yorkshire and Humberside branch – an organisation that had always played a significant role in the life of social care in Yorkshire and Humberside. She recalls Pat Nolan talking of ADSS a lot, and "indeed, as a senior manager I was always encouraged to keep up to date with what ADSS, and then ADASS, were doing."

She is still an avid supporter of the regional structure, the support and sharing that branches give their members, as well as the interface and cross-over. "So, if you like, I've sort of grown up in my career being acutely aware of ADSS/ADASS. This year is a particularly interesting and important year because of our extended membership, and the more overt opportunity it gives us for supporting and encouraging the next levels of leadership. This extension to ADASS membership has given us a real opportunity to do this.

"We've got to invest in our future leaders. This opens up some of the opportunities directors have had in terms of the conferences assistant directors can attend; and broadens the engagement with the leadership development networks that Jo Cleary has been heading up. And we must encourage people to participate, and contribute."

As well as this, one of her ambitions for her year is to develop further social care's relations with the commercial, voluntary and community sectors. "I do see it as an area for new conversations, new relationships and new developments. And I feel, also, as though this year will be one where we concentrate on consolidating progress and existing work in ADASS, developing the social care workforce and building on sector-led improvement alongside the integration agenda with the NHS" she says.

Very happily married she lives in Sheffield, (though stays in a crash-pad in Leeds during the week), with her husband. She has two step children, one in nursing and the other living independently with a disability. She is intensely proud of them both. She met her husband working in Barnsley (he opened a children's and young people's assessment centre which she, subsequently had to close, 30 years later).

Her mother, at 89, is still living in the community and her recently bereaved, 95 year old mother-in-law lives in a Sussex care home. Sandie's is a family rooted in and firmly aware of the triumphs and difficulties within the services they run, work in, and use.

Hobbies? Pastimes? She admits to reading crime novels and enjoying travel, and the local Peak District, while her church activities take what little time she has spare. "To be honest I don't get a lot of time for hobbies at the minute. I live in Sheffield and Leeds, and I spend a lot of time in London: work expands! But when I can, I love entertaining; I love cooking, and I love throwing parties for large numbers of people in our home." Anyone who received a Christmas card from Sandie will know of her love of making cards and working with paper. "I love paper. I don't know what it is, but I love hand-made or unusual materials and putting them together in all sorts of creative ways."

A bit like running a social services department, maybe …?

Building new partnerships

Time is a funny thing! In a way the last year seems to have flown and in the last few weeks a whole range of colleagues from partner organisations have been saying they can't believe my year is nearly up... Hasn't it gone fast? And yet, *writes Sarah Pickup,* somehow, the beginning of my year as president seems like a very long time ago. Even the year's punctuation marks... the jubilee, the Olympics... feel like a distant memory! What is in no doubt is that it has been a busy year in extraordinary times, with some significant milestones for social care.

Sarah Pickup

Our ADASS business plan for 2012/13 was framed in terms of relationships with:

- Providers, the market and regulators
- Citizens
- Workforce and
- The DH and newly emerging DH structures

And it is fair to say that much of my year has been spent working on developing and sustaining these and other relationships... Relationships with the media is probably one for the personal plan of any incoming ADASS president! A slightly unexpected addition to the list here was the need to form relationships with a new Minister of State for Care, Norman Lamb and with a new Secretary of State for Health, Jeremy Hunt and a new Chief Executive of CQC, David Behan, known to us well in his previous roles of course.

I wrote in the October edition of *Futures* about the core content of the care and support White Paper and the draft Bill. Since then I and ADASS colleagues have been engaged in discussions about the practicalities of implementing the reforms; I have given evidence to the committee undertaking the pre-legislative scrutiny of the Bill, and ADASS has taken its seat at the DH's adults social care implementation group and at the adults social care Implementation Board.

These social care reforms are, of course, running alongside the changes to the NHS triggered by the Health and Social Care Act. DASSs and ADASS have key roles to play in these reforms too, as members of health and wellbeing boards and often with the lead for health in local authorities prior to the reforms. Yet these reforms push more deeply into local government with the transfer of public health, and health and wellbeing boards set up as committees of local authorities with a remit for all citizens, adults and children.

In this context new partnerships have emerged during the year. We have always worked quite closely with the LGA but with the significant implications of health reform for local government and adult social care recognised as one of the LGA's top priorities, we have been working more even more closely together as well as engaging with SOLACE to build a system leadership model with the emerging NHS commissioning board.

This new style system leadership is essential to tackling our joint priorities which include the follow up to the Winterbourne View report and driving forward integration to ensure that care is coordinated around the needs and wishes of the individual and best use is made of the public pound. Work with markets, providers and regulators has also been an important strand of activity this year.

The programme of work on `developing care markets for quality and choice' has seen ADASS nationally and DASSs and their staff up and down the country acknowledging the importance of working with providers and local markets and moving to produce market position statements that will assist in future planning.

"Work with markets, providers and regulators has also been an important strand of activity this year."

When set alongside JSNAs these will help in developing a common understanding about future service requirements. Alongside this development programme we are directly engaged with the major national provider organisations such as ECCA, UKHCA, RNHA and VODG through our work with TLAP and a range of other activity including some work to improve transparency around pricing.

It is also true to say that ADASS has been working in alliance with both independent provider and voluntary sector organisations to continue to highlight the need for funding reform both in terms of the recommendations of the Dilnot commission and the wider question of the quantum of funding for adult social care. Despite the ongoing tensions not to mention judicial reviews in some parts of the country, there is a growing realisation that an `us and them' relationship between providers and commissioners will not resolve the issues between us around cost and quality, pay, costs and prices.

We are better off trying to develop a common understanding and ensuring that valid concerns about low pay in the sector are fed into CSR and reform discussions and that we build on the clarity of our respective responsibilities for quality of services that is set out in the White Paper. The `take a commissioner to work' initiative we have agreed to take forward in partnership with UKHCA is an example of the efforts we can make to promote common understanding.

In relation to the funding reform, of course the government has now announced its intention to implement the Dilnot commission proposals in full, albeit with a higher cap than suggested. ADASS has welcomed this decision as providing a resolution to one of the long standing funding issues but will continue to work to raise awareness and understanding of funding pressures on adult social care in the context of reductions to government grants to local authorities and the squeeze, if not freeze, on council tax increases.

"Wider government beyond the DH and even into Number 10 has taken an interest in adult social care."

We have an opportunity to present our case as a submission to the spending review for 2015/16 and our annual budget survey will provide vital information to support this case. We are working closely with the LGA, SOLACE and the DH to clearly establish the pressures on the system, acknowledging that there are some savings that can still be made but being clear about the likely implications of a continued squeeze on spend.

With the focus on the bill, the White Paper and Dilnot reforms, it has been a year when wider government beyond the DH and even into Number 10 has taken an interest in adult social care.

One example was the launch of the Prime Minister's Dementia Challenge which has brought a much wider focus on the lives of people with dementia and their carers.

I was delighted to be asked to co-chair one of the champion groups set up to drive forward the Challenge and my co-chair, Sir Ian Carruthers and I have been working with the DH and a wide group of stakeholders to drive forward

Avoid unneccessary admissions

improvements in health and care for people with dementia and their carers. I have had the opportunity to speak to a wide range of audiences about the challenge as well as meeting with the Secretary of State who has identified dementia as one of his priorities too.

On each occasion I take the opportunity to point out that most people with dementia are supported to live in their own homes by family carers and often with the support of social care services especially homecare. This fact is too often forgotten in the drive for early diagnosis, appropriate use of drugs and good hospital care. All of these are important of course but it is also critical that GPs and hospital consultants are informed about the kind of services we can offer to support people with dementia... Specialist homecare including enablement, extra care housing, telecare etc, so as to avoid unnecessary admissions to care homes especially from hospital.

In this work on dementia, and through much of the other work I have done this year on ADASS's behalf, I have had the opportunity to learn a lot and have met huge numbers of dedicated people across a whole range of organisations as well as experienced the generosity of service users and carers in sharing their experience and expertise to help others and to inform those of us who seek to offer support.

"I have had the opportunity to learn a lot and have met huge numbers of dedicated people."

During the year I have received amazing support from the ADASS business team, from many directors and assistant directors (drawing on our wider membership) and from my own team back in Hertfordshire. I have found partners receptive and keen to work with us and the Department of Health keen to continue with the co-production we have seen in the last year or two.

It is sometimes hard to represent 152 authorities and often not possible to explain the reason for taking a particular line at a particular time in detail to all. All I can say is that I have done my best! It has been a huge privilege to be the ADASS President and I know that, as I hand over to Sandie Keene for the year ahead, our newly expanded association will be in good hands and that you will all be willing to play your part in supporting Sandie as you have supported me.

Sarah Pickup
President, ADASS
2012-2013

Heard the one about integration?

There is a well-worn story in which the country is laid waste by nuclear apocalypse and only two things survive; one is cockroaches, and the other is a small group of people huddled together amongst the ruins conducting an earnest seminar about how to integrate health and social care, writes Richard Humphries.

Richard Humphries

Calls for integrated care have come thick and fast. A particular gauntlet was thrown down by the Health Select Committee last year when it called for fragmented commissioning and multiple funding streams to be replaced with a single commissioner for older people's services in every local authority, with accountability for a single pooled budget.

The argument for better coordinated care is unassailable, but how to achieve it is not straightforward. That's why ADASS has initiated discussions with national partners, facilitated by the King's Fund, about how a more integrated approach to commissioning could be achieved. The upshot has been lots of practical and positive ideas for a new programme of work to help DASSs and their partners work out local approaches and solutions.

There is unanimous agreement that if the desired outcome is for people to have an integrated experience of health, care and support, the means to achieve this will vary from place to place - a single national model of integrated commissioning will fail to reflect the diversity of local circumstances. In the same way that the Government has recognised the need for focused support to help local authorities develop their important new market-shaping responsibilities, there are practical steps that could be taken to support local authorities, CCGs and the NHSCB locally in ensuring that their commissioning activities result in better coordinated care for older people.

The outcome of these discussions has led to an agreement with the Department of Health and the NHS Commissioning Board to commission a practical toolkit for use by local commissioners and health and wellbeing boards. This will be co-produced by ADASS in partnership with NHS Confederation, LGA, Royal College of GPs and the British Geriatrics Society.

The toolkit will be framed in the context of the national outcome frameworks for the NHS, adult social care and public health and the NHSCB's Supporting Planning Framework for 2013/14. An important focus of the work will be achieving better commissioning across these different planning and frameworks - at the level of systems rather than individual organisations.

The initial programme will draw together existing best practice and emerging innovation in the use of local public service resources across organisational boundaries to deliver better coordinated and integrated care for older people. Three stages of work are proposed:

An initial scoping exercise to map existing initiatives and programmes of work, particularly in the area of integrated care, to avoid duplication and ensure synergies and connections with relevant work, especially the common purpose framework expected from DH in late spring,

Some engagement events to discuss with end-users the specific tools to be developed and to identify any particular issues, challenges or opportunities that should be focused on, and in the light of this to agree with DH, NHS colleagues and programme partners the key outputs and deliverables,

The development of a package of materials, such as short guides, web-based tools, templates and checklists - with signposting to other sources of information and evidence. The specific products would be agreed through discussions in the previous stage, but could cover the following areas:

Self-assessment and development tools that local commissioners could use together to map use of resources/costs across different parts of the health and care system; analysing the use of services at individual and population level based on existing care pathways by linking individual data from health and social care sources; understanding variation in spend, activity and performance; to identify local areas for improvement.

- Bringing together these different elements to produce a composite picture of what 'good' would look like in relation to integrated commissioning for older people.
- Developing templates for developing local integrated commissioning arrangements, with case studies and examples.
- Producing practical checklists to help health and wellbeing boards deliver a local strategic leadership role in driving forward integrated commissioning.

The intention is to develop these products through a mixture of desk research and onsite development with local authorities and CCG partners. There is much to do and plenty of opportunities for directors to help shape this work. This will form part of the discussion at the Integration meeting led by Sandie Keene directly after the ADASS AGM.

Richard Humphries
Assistant Director of Policy, King's Fund
Joint Lead, Associates network

Working for social justice

How difficult could it be? *asks Glyn Jones.* The announcement appeared on the face of it to have been triumphed in Local Government quarters as 'public health coming home' and in equal measure dismay by some in public health expressing concern at a move away from public health roots! despite many authorities having prior joint arrangements.

The opportunities are monumental...

It did seem at one point as if the whole debate was characterised by the status and reporting arrangements of DPHs or funding. And whether this was another 'hot potato' for local government. Meanwhile significant opportunities for improving outcomes for local people appeared to get lost in the midst of the propaganda!

"This gives us the chance to move away from what some may characterise as 'health fascism'. "

The reality of course is that local government has significant experience of working collaboratively with a range of organisations in a variety of different ways. Indeed back in 2006, the guidance documents on the role of DASS was clear about our responsibility for assessing local need and links to the health and wellbeing of the populations. Indeed such is our position within councils that many of us have responsibility for activities and services that we know contribute massively to the 'wider determinants of health'.

I believe the size and shape of local authorities with two tier, unitary, metropolitan and London boroughs means that the move from a single approach to organisational structure (as in PCT) cannot be replicated, nor indeed should it be if there is serious ambition to respond to local communities. Clearly there is a range of different arrangements in authorities and even sharing of DPHs and whilst initially this has helped to deflect the task away from improving the health of the population, it will enable the best opportunity to improve integration.

All authorities have a range of health inequalities to tackle. Indeed this aspect of public health is crucial in improving self help and care to impact on self esteem, worth and independence and to help avoid reliance on long term health and social care systems.

This gives us the chance to move away from what some may characterise as 'health fascism' or the 'rise of the nanny state' to quote a colleague. We know that there is a very real opportunity to make every contact a public health contact.

I have been impressed by the willingness of councillors to want more information about their wards from the JSNA material and harnessing their knowledge of their ward with the data to influence and shape local health and wellbeing strategies. An interesting by-product has been the political relationship with CCGs - in particular the clinicians whom they see as having a shared interest in `their' local people.

"There is an incredible number of examples of fantastic integration building up."

As we move away from a frankly indifferent transition period, the opportunities presented are monumental, even (or perhaps) despite the difficult times. There is an incredible number of examples of fantastic integration building up from local areas, links with CCGs, proving that structure and location, reporting lines do not stop those who want to help to improve the lives of people in our communities. I am minded to reflect that this is of course, where ADASS has its heart in 'Working for Social Justice'.

Glyn Jones
ADASS Lead for Public Health

Glyn Jones

Changing mindsets…

Richard Webb writes: To misquote Jane Austen, in this the 200th year since the publication of *Pride and Prejudice:* "it is a truth universally acknowledged, that a local authority in possession of an adult social care service, must be in want of integration….."

Richard Webb

Once again, integration is trending heavily in the social care and NHS policy ether. While integration with the NHS is a vital component in improving care and support, it is only part of the story.

According to the Oxford English Dictionary, integration, in its psycho-analytical definition, means the process by which a well-balanced psyche becomes whole. For those of us who learned our social care via John O'Brien's *Five Accomplishments,* integration is about inclusion, independence and social justice. The lessons from the personalisation movement have reinforced that broader approach.

For me, independence and inclusion are the WHAT and integration and personalisation are the HOW. So, perhaps it's worth reflecting on the other dimensions of integration that are relevant to the people we work with and the wider responsibilities which many DASSs have.

Most DASSs have a broader remit beyond adult social care. About a third of us are responsible for children's services. Many of us have responsibilities for housing, leisure, libraries, arts and community safety. Some of us empty the bins and provide public toilets, too. At its best our focus combines people and place: the intangible fabric which weaves together our communities.

Over the past decade, we have been on a voyage of discovery (or, for those of us who have been around a bit longer, is it re-discovery?!) with much stronger relationships being developed between adult social care services, the wider community and other public services. This has been driven by a desire to work with people to promote good health, to open doors to better life chances and to make the most of individual and community assets.

Some of the best preventative work with the most excluded people is taking place in housing. Libraries are joining up with primary and social care to provide self-help on prescription, particularly for people with mental health issues. Arts and culture colleagues are encouraging new and seldom heard voices to be heard in ways that we never quite succeeded in doing in the past through somewhat worthy and bureaucratic means.

Trading Standards teams are doing great work to stop door-step crime and make older people feel more confident and secure. People are using their personal budgets to buy into community activities and even to set up small businesses: care and support is becoming the springboard rather than the end in itself. In some areas of the country, councils are beginning to debate whether 'social care' in itself is becoming an outdated and restrictive term – are we moving towards a citizenship service?

This optimistic picture is not universal. There are people who are not able to access what the wider community has to offer. There will also be places where making the most of individual and community assets feels easier said than done in the face of economic recession, deficit reduction, graphs of doom and welfare changes.

However, there are some important opportunities which we need to hold onto and nurture:

The new integration is about connectedness - with public health moving into local government, we have a better chance to tackle root causes of poor health, inequality and exclusion. The Marmot Review emphasised loneliness as being amongst the biggest predictors of ill-health and hospital admission. Thinking creatively about how we address isolation gives us an opportunity both to help people transform their lives and to develop a narrative for integration which brings together real issues in people's lives, the involvement of the wider community in finding solutions AND a potential value for money benefit to the NHS and social care – integration in the new world should be about this kind of connectedness, not just a re-heating of the structural integration that was fashionable a decade ago. This is about mindsets and behaviours.

We need to draw our inspiration from beyond the usual suspects. In Sheffield, the company leading our major PFI programme to improve all the roads is actively working with older and disabled people to look at what and how this work is done. And a local housing association is using its neighbourhood networks, to work with local people, public services and voluntary organisations to start creating a dementia-friendly community.

We need to become more ambitious about the economic potential of social care: in many places, the care sector is within the top ten of major employers. Recent studies about realising the growth potential of the North's economy cite this opportunity. Colleagues in Scandinavia, the Netherlands and Germany are already thinking along these lines. We know that social care is a growing sector in employment terms: it also has the potential, through personal budgets, to stimulate new markets and enterprise, and, it needs to be better organised in sponsoring technological innovation.

So, integration really does matter. And we know that it's the contemporary, multi-faceted version, which has the most potential and the furthest reach.

Richard Webb
Honorary secretary, ADASS

Getting real about outcomes

There has been a considerable focus on integrating health and social care in the last year including the Care and Support White Paper; the formation of Health and Wellbeing Boards with a brief to promote integration; various statements by the new Secretary of State and the Care Services Minister; the work of the Health Select Committee, and a focus on whole Place Community Budgets pilots, *writes David Pearson.*

The main drivers have been the development of `seamless' services and recognition of the performance and financial links between the NHS and social care. The recent Ernst and Young report on whole-place community budgets argued that the net annual benefit from joining up funding across public services to health and social care might be between £2.8bn and £7.9bn. While this comes with a large number of caveats, the sums being discussed are very large.

"Real success must be measured by improved outcomes for citizens as a result of integration."

Lord Warner, a member of the Dilnot Commission, said that directors of adult social services should `cosy up' with Clinical Commissioning Groups. While the Health service has its own £20 billion challenge, the NHS budget is approaching ten times that of Adult Social Care nationally and its protected status in terms of reductions in public spending means it has the capacity to support social care beyond the very welcome NHS support to social care funding.

So what do we mean by integrated care? In reality, it is a variety of arrangements from close coordination of commissioning and provision to merger of organisations. Previous measures by all governments of the success of integrated care have been the extent to which there are joint posts or pooled budgets as a proxy for effective arrangements. However, real success must be measured by improved outcomes for citizens as a result of integration and the financial benefits. Integration is not an end in itself, but only a potential means to improving outcomes and value.

Research evidence suggests that integration works best when:

- Leaders are able to share and articulate a clear and unified vision
- The outcomes required are identified
- Resources and activity are aligned to meet the outcomes

Joining up commissioning or providing?

The Health Select Committee has proposed one commissioning system. This does not necessarily mean that those carrying out the task have to belong to one organisation, but that the whole of health and social care spend for older people is considered together.

This makes a great deal of sense. Integrated Commissioning has been characterised in many places by considering jointly only those areas where it is difficult to avoid it. This includes adult mental health and learning disability, but for older people it has often been intermediate care, reablement, and areas of service where continuing healthcare and social care butt up against each other.

Approaching half of local health service expenditure is spent on hospital care. Approximately two thirds of those occupying hospital beds at any one time are older people. The Public Audit Office has identified that approximately 30% of those in hospital beds at any one time could receive their care outside hospital.

Similarly, social care authorities spend a significant proportion of their funding on residential and nursing care for older people. Integrated commissioning provides the best opportunity of meeting the aspiration of the vast majority of older people to remain in their own homes and the financial challenges facing health and social care.

An understanding of the financial and service benefits of investment in social care could lead to a clear commitment to the transfer of funding to meet those objectives.

The best approach to integrating provision is less clear cut. In health and social care there is an increasing number of providers in a mixed economy of care. In Nottinghamshire direct gross public spend on social care services is £283m of which £226m is spent on well over 300 organisations. How do we join up all this provider activity with health? The fact is we don't need to integrate in all areas.

The key is making sure that services are integrated where there is an evidence base of improved outcomes and better financial performance. There are examples where integration hasn't delivered the high hopes expected and financial difficulties have been experienced. A pooled budget without an understanding of how costs and demand will rise or be contained has led to serious financial difficulties.

The advent of Health and Wellbeing Boards as system leaders provides a once in a lifetime opportunity to integrate commissioning. The key is to be clear about the outcomes, costs and benefits.

David Pearson *is a member of the Health Care Transitions group, and Corporate Director, Adult Social Care and Public Protection, Nottinghamshire County Council.*

Where there's a widget…

It is the job of the Care Quality Commission (CQC) to register, monitor and inspect all health and social care providers in England to check that they are meeting the national standards of safety and quality, *writes Mike Reed.*

Mike Reed

The Commission is focused on improving public awareness and understanding of what we do with the aim of:

Empowering people with knowledge of the standards they should expect when receiving care,

Increasing use of our inspection reports to inform decisions about which care service to use,

Increasing the amount of information we receives from the public about their experiences of care which informs CQC's inspection work.

In order to promote its role and encourage public feedback, CQC's Public Communications team has identified the country's leading charities as an effective way to reach people who use services, their relatives and carers.

Through the charities' own channels, we are able to convey our message directly to users and carers, at the point of need, when it's relevant. We have already established communications partnerships with 20 leading charities including Mind, British Heart Foundation, Age UK, Terrence Higgins Trust, Mental Health Foundation, Epilepsy Society, Choice Support, Carers Trust, Dementia UK and Mencap.

Through the relationships we have built with these charities, we have been able to secure CQC articles in their online news and printed magazines, and we've also worked on some more bespoke communications opportunities.

Mind has hosted a blog entitled, *An Inspector Calls* in which a CQC inspector recalls a series of inspections she carried out in direct response to feedback we received from an anonymous member of the public. The blog can be viewed at http://www.mind.org.uk/blog/7780_an_inspector_calls.

And a CQC compliance manager hosted Carers Trust's monthly webchat resulting in a lively chat about how CQC uses information from the public to directly inform its inspection work. A transcript of the webchat can be found at

http://www.carers.org/hosted-chats-2011.

One of the more prominent partnership activities involved a series of programmes broadcast on Age UK's online radio station, The Wireless, which also goes out on DAB across Greater London and Yorkshire. The project involved the production of four, fifteen minute programmes produced in partnership with the charity, including an interview with CQC's Chief Executive, David Behan.

The programmes, which can be heard at http://www.cqc.org.uk/node/672775?clearcache, have been re-run on The Wireless, and been made available through the Hospital Broadcasting Association (HBA) to all of its 217 member stations serving 421 hospitals.

The charities are also very keen for us to brief their helpline teams on CQC's services.

We provide information about CQC's role, the value we place on information from the public, and what information is available from our website and through our National Customer Service Centre. We recently briefed the British Heart Foundation helpline team which felt that our information would prove invaluable in advising many of their callers and, over the next few months, we are due to brief the helpline teams at several more leading charities.

CQC would like to extend that work to local authority social care helpline teams as we know some of their callers will have very similar concerns to those people calling the charity helplines. People's experiences of health and social care services are extremely valuable to us, as they directly inform our inspection work. We also want to make our information and messaging available to people at the point they receive a social care needs assessment, which is something we're keen to explore with councils.

CQC is also encouraging health and social care providers as well as other organisations to incorporate its recently launched widget on their websites. The widget gives up-to-date info on the quality of services plus one-click access to the latest CQC inspection reports and findings. Organisations regulated by the CQC can embed the widget on their sites, but it's also a useful tool which local authorities can use.

If your local authority website has an online directory of health and care services, why not consider using the free CQC widget on your site? It will give your users access to valuable information to help them make informed choices about services. You can find out more at www.cqc.org.uk/widget. Since its launch at the end of last November, more than 1,700 organisations have snapped up the widget including several local authorities and the care review sites Good Care Guide, Compare Care Homes, and Find Me Good Care recently launched by the Social Care Institute for Excellence.

In return for providing charities and other organisations with content of interest and value to their audiences, they're helping CQC to talk directly to its core target audience and encourage feedback that will help improve care for everyone'.

For further information about this work please contact Mike Reed mike.reed@cqc.org.uk

Mike Reed
Mike Reed is a member of the care Quality Commission's public communications team

Immune to the sound of pain…

"The system! I am told on all hands, it's the system. I mustn't look to individuals, it's the system… My Lord knows nothing of it. He sits there to administer the system…HE is not responsible. It's the system." Peter Hay applies Dickensian logic to inquire what the Mid-Staffs scandal means for social care.

Peter Hay

This is the outpouring of rage by Gridley in Bleak House, Dickens' portrait of the grinding and all consuming nature of the Victorian legal system. A system that even the most powerful people inside it were unable to affect. It could equally be an expression of some of the frustration that some felt after a reading of the Francis report. Except for a key difference. Unlike the judges Dickens portrayed, we have the chance to change our system: we are neither powerless nor overwhelmed by it.

I haven't watched social care sit this one out as a problem confined to hospitals run by someone else. We share the ambition of creating dignified and safe health and care systems. Francis is clear that his report must be a call to action, and that includes how we find our way to play our part.

The studied examination of large amounts of evidence and testimony by Francis concludes in 290 recommendations that the deaths of around 1200 people require cultural change within the NHS. For many of us, as well informed members of the health and care system, the call for culture change is easily understood.

Our thoughts should start with the relatives whose " completely understandable anger" in the words of the Prime Minister is perhaps closer to Gridley's rage and confusion.

For some of the relatives, no one seems able to change the system simply because it's too big and too remote. An inquiry is not an end in itself and the Government's response to Francis will have to bridge the gulf between the scale of the task and the need to show momentum towards a better and safer system. It will also need to sit alongside and support the mobilisation of leadership influence upon the system. This is not an issue for Government alone. Local government can bring its strength in public engagement with its new powers in the health system to show that we are part of a credible change in culture. If the starting point of that new culture is to be authentic, patient-centred care, that means staring into the face of the unacceptable.

The NHS is for all of us, and we need to have complete confidence that if, or perhaps when, we require hospital care at some point in our lives, we will get care be of a high standard. I do not expect the NHS always to be able to cure me of whatever might befall me. But I do expect it to keep me fed and watered. I am not sure that the NHS will be able to extend my life. But I know full well that the NHS should not shorten it.

Mid Staffs failed when measured against my top two expectations.

It is imperative that the cultural change programme should speak to these most basic definitions of being patient-centred: to not make the mistake of over professionalising the personalised. The system and its culture have to have a human face expressed by a new-found certainty that it can meet basic human needs in a way which Mid Staffs tangibly failed to do.

For me, its the simplicity of personalised care that is the most important task - yet also the most difficult. In this increasingly complex, bureaucratic and legalistic world, it's easy to make caring for people complex. Any fool can come up with new forms, checklists and paperwork to try and make something happen or more likely, to prove afterwards that `something was done'. Appropriate, compassionate and personal care cannot, by its very definition, be prescribed in advance and captured in a glorious procedure manual. Great professionals know when to put the book down and `do the right thing(s)' and are supported by leaders who share these values.

Leadership today means the hard work to create the space for professional staff to focus on the personal while providing political and public assurances on productivity. Dympna Cunnane and Robert Warwick, writing for the Guardian Professional site, make the case for a new approach that can face two ways to deliver both efficient, reliable administration and compassionate care.

"Organisations need to be designed with their core purpose in mind, from the outside in, which means mindful leaders who can bridge the gap..." I can not exempt myself from questioning how "mindful" my leadership is. As I write, Birmingham is preparing for a peer review, looking at how we have balanced quality, safety and dignity with the major reductions in our budget over the last three years. I question whether the £ signs have come to dominate the agenda.

More hopefully, I know how hard we have tried to balance reducing resources by a third against social care values. Birmingham's politicians are bravely struggling with a current review process that is trying to lead with core values within further diminishing resources

MID STAFFORDSHIRE

The NHS is for all of us, and we need to have complete confidence...

over the next four years. The test remains whether we can make the `outside in' balance with still less resource.

Mindful leadership would also recognise that supporting the most vulnerable of people takes a toll upon the individual. Bev Fitzsimmons at the Kings Fund suggests a need to acknowledge "the unprecedented pressure...dealing with illness and distress day in, day out."

I recently had a letter complimenting staff, where their support for a family at the time of the loss of their mother had included a manager coming to sit with them during the small hours of the night. This was rightly recognised as outstanding practice and commended by the family for the huge difference it had made to them. However big and demanding the day job, the manager had given of himself and his own time to respond to human loss.

The direct opposite is the most chilling comment in the evidence to Francis which came from the nurse who said that they had "made (themselves) immune to the sound of pain."

Practitioners who make themselves open to others make themselves vulnerable.

Some, although not all, of stress-related illness might be about, and stem from, exactly such commendable practice. I am probably not unique in being very target driven on sickness levels at present, yet mindful leadership at least pulls me up to remember that even this task is multi dimensional.

So it maybe that at the core of this complex cultural change requirement lies the multi-faceted nature of the leadership task. Great leadership is complex and multi-dimensional, where contradictions arise at every turn. We should assert this as our role, dealing with the complex so that we clear a route to the truly personalised care required at the sharp end of the business. Making the business of leadership too simple, through the application of mere targets for example, should therefore be a warning sign.

The Kings Fund suggests eight factors in securing the right culture, all of which carry their own complexity. Real cultural change will be based on an acknowledgement that leading in care systems requires a skill and competence in public sector management that should not be denigrated or relegated to a lower level than the wealth producing management of the private sector. Public sector management has a multi-faceted nature, and the answer to whether people get great compassionate care will never come from a target or any other singleton approach.

The task of leading these great systems will need valuing and nurturing too. Dickens sought to challenge Victorian England to face its unacceptable sides. Francis perhaps is taking us into meeting an equivalent challenge for our times. It might be difficult for us to comprehend the scale of the basic cruelty revealed by the report. It might also be that perhaps none of us finds it that easy to accept our mortality, let alone want to consider how we might spend our final days in hospital.

There is much that leads us to want to leave such uncomfortable things in the `too difficult' box, or to consign them to a convenient blind spot. We can seek to justify such a choice by using cultural change as too vague, too amorphous or too vast. This is not acceptable: none of us wants to picture a death foretold by a Mid Staffs experience or similar.

I came to love "Bleak House", probably because it was there for five years of my life. Its call for systems change stuck deep with the younger me. I wanted to alter the way the whole thing worked. I was intolerant of power that blocked out the possibility of better. It was that very commitment to system change that resonated with the choice of social work as my career path. Francis is a reminder of that radical inner voice, the discontent with systems that entrap people to cause pain and hurt.

I get cultural change. And I recognise that I am a part of that change. Bring it on, and bring it fast.

Peter Hay
Strategic Director for Adults and Communities, Birmingham City Council

Opportunities knock

I am writing this article two weeks out from starting my role as director general of social care, local government and care partnerships and still in the midst of handing over my responsibilities as chief executive at Croydon, *writes Jon Rouse.*

It is an exciting time to be joining the Department, just weeks before a number of the main structural reforms set out in the Health and Social Care Act take effect. For the Department itself, April 1 is an important landmark in our own transition to becoming stewards of this reformed system.

Each of the DH director generals' responsibilities span the reformed system and this will require us to work seamlessly as a team in support of Ministers and the permanent secretary. For example, I have responsibility for the development of Health and Wellbeing Boards but underpinning their work will be the contribution of the local public health teams and Public Health England, and the Boards' strategies will only be as good as the NHS and social care commissioning plans that flow from them.

It is therefore inevitable and, in my view, a positive thing, that my relationship, and indeed, the Department's relationship with the adult social care sector will increasingly be characterised by a whole system approach. In other words, if I am contributing to the stewardship of the whole health and social care system, then one of my primary considerations will be how can the adult social care sector best contribute to securing the outcomes set out in the national frameworks and the priorities agreed by the local Health and Wellbeing Boards. My starting point is that the sector itself will best know the answers to those questions and that those answers will differ from locality to locality.

A significant part of the planned social care reform still of course lies ahead of us in the form of the Care and Support Bill. This will now include a set of additional clauses to capture the Government's proposals for future funding of social care. I have already listened to ADASS's helpful evidence to the pre-legislative scrutiny of the Bill by the joint select committee. The Department is committed to continuing a strong partnership approach as we refine the Bill and develop the secondary legislation and guidance.

In the coming months it is right that the Francis report and the Government's response to the report will dominate much of our agenda. Clearly, much of the report is as relevant to the social care sector as the health sector, and we have to ensure that this understanding is infused throughout the sector – commissioners and providers alike *(See Peter Hay, Immune to the sound of pain…. Page 20).*

The report has hard-hitting messages and recommendations on a range of relevant issues, including commissioning, community voice, staffing levels, whistleblowing and leadership, that we must engage with fully in respect of the required response of the social care sector. The report also has some tough words on regulation, and in particular, the limits of self-regulation, that will require reflection and response.

There is one paragraph, 1.43, in the Executive Summary of the Francis report that I keep coming back to:

"The underlying reason for the failure of [the health authorities] to adequately seek out or address patient safety and quality concerns about service provision at the Trust, was a failure of the leadership to give sufficient explicit priority to the protection of patients and to ensuring that patient safety and quality standards were being observed there. In common with the system as a whole at the time, the focus was unduly directed at financial and organisational issues and an over reliance on assurances given by others, while losing sight of the central purpose of the service it was seeking to support."

It is a statement that provokes a number of questions. How does the adult care sector ensure that it maintains focus on what matters, particularly at a time of significant resource constraint? Does each local authority have a safe and supportive environment where people within the system can speak up and speak out when they have concerns? Is the peer support framework and the production of the local account a robust and challenging enough process that we can say confidently that we would know if there is a risk of serious failure occurring somewhere within the system?

And finally, although certainly not exhaustively, how do we make sure that the new sectoral responsibilities in respect of local market oversight can also provide additional assurance in terms of provider quality and safeguarding?

The response to Winterbourne View is a real opportunity for the social care sector, working with the NHS and many other partners, to demonstrate its agility and creativity in enabling a particular set

It is difficult to think of a time when your leadership has been more important.

of service users to live in a more humane and caring environment – a home, not a hospital. It was encouraging to see how rapidly all the required partners signed up to the shared action plan and we now need to ensure that this is made reality on the ground.

In addressing this challenge, there is also the chance for the sector to exemplify its commitment to enabling service users to live 'in community', in other words, to create living environments where vulnerable adults are not treated as passive recipients of services, but rather as people who are able in most cases also to contribute positively to the life of their immediate community, whether within a residential home or a wider community setting.

A related agenda is the Department's commitment to drive forward greater integration both within the health sector, and between health and social care. Within the interface between health and social care, there are of course different types of integration – of needs assessment, of care management, of commissioning, of provision. In all cases, integration is a means to an end, not an end in itself. The key question in every case is whether, by joining together, we achieve a better set of outcomes for the service users and their carers, as well as operating more efficiently, usually by preventing costs arising elsewhere in the system.

In Croydon, we created one outstanding model, our Integrated Memory Service, made some good progress on co-ordinated discharge and reablement, and are still in the foothills in respect of integrated care management for people with long term conditions. My own experience of seeking to make integration work has convinced me that true commitment only comes when all required partners are incentivised to secure the same set of outcomes, including, where necessary, to reduce activity levels that are low contributing but expensive, and that the derived financial benefits are shared equitably.

I would like to end with a few words on workforce development which will continue to be a key priority for the Department in its work with the sector. My own father was a social worker and so, even if I had never run a local authority as demanding in its service needs as Croydon, I know how tough the job is – the judgements involved in balancing needs and resources, the personal emotional cost, that sense of being always on duty, particularly at the most senior levels of the profession.

It is difficult to think of a time when your leadership has been more important to the profession and the people you serve. It is not only about maintaining a motivated, skilled workforce within local government, but also about system leadership. How do we create a values culture that ensures that any home care assistant entering the house of a vulnerable adult on any given hour of any given day, no matter which provider they are working for, is committed to compassionate care based on principles of respect and dignity? That is a daunting challenge. It is part of the challenge that Robert Francis lays down.

And it is this challenge, more than any other, that I want to work with you to meet.

There will be many occasions when I can and will champion the role of the adult care sector within the Department and Whitehall. But at the same time, the reformed system relies on distributed leadership and there are distinct and crucial roles to be played by the new Chief Social Worker, the Care Quality Commission , the Social Care Institute of Excellence and the National institute for Health and Clinical Excellence, among others.

What I will seek to ensure is that there is consistency in our relationship with the sector, a clarity of narrative and a collective commitment to joint working in the development of policies, standards and solutions. I intend to stay connected to what is going on at service level and would welcome invitations to spend time with you on your patch and to see, first hand, examples of good practice. There is much to be done and I very much look forward to working with you.

Jon Rouse
Director General of Social Care, Local Government and Care Partnerships

Celebrating the workforce

We have all become accustomed to the doom and gloom portrayed by the media about our sector. Failing care homes, abuse and care workers who do anything but care. While it is right that failures are reported by the media, it should be in the context of the outstandingly good things that happen in the sector in the vast majority of cases, and the benefits that good social care brings to individuals and the UK more generally, *writes Lisa Carr.*

Lisa Carr

I have been privileged to be involved in the Great British Care Awards since its birth some five years ago. The awards celebrate excellence in social care and are supported by the Department of Health and ADASS. For any sceptics out there I would recommend sitting in on a judging panel for one of the awards categories. Each year I never fail to be amazed by the quality of the finalists. I never cease to be touched by the heart-warming stories of care workers who live and breathe care in order to make a real difference to the lives of others. They are inspirational individuals who by the very nature of their beings are bemused as to why they are being rewarded, for what for them is a passion and a vocation; not just a job.

Of course good quality care provision is due, in part, by companies who invest in training, developing and retaining a well motivated workforce. But being truly passionate about caring comes from within. It's not something that can be taught in the classroom but something that should be nurtured and developed through a supportive culture of learning.

This year the Great British Care Awards received a personal pledge from the Minister for Care Services, Norman Lamb – an encouraging sign that those representing our sector in government also recognise the value of excellence in our frontline care staff. At the latter end of last year, following the regional awards, a group of winners were invited to meet Mr Lamb at the Department of Health offices in London's Whitehall.

The group, representing a diverse range of category winners from throughout the regions, were tasked with briefing Mr Lamb on the challenges that the frontline social care workforce face. They also gave examples of how they had overcome these challenges with examples of great innovation. Mr Lamb promised to take these issues on board and was keen to have similar roundtable discussions in the future. Long may this enthusiasm continue!

Last year *Care Talk* magazine launched Good Care Week, a national UK -wide awareness campaign that will take place week beginning 22nd April 2013.

Supported by ADASS Good Care Week is a campaign that will see local initiatives come together to create a national movement, celebrating and promoting excellence in social care.

Social care has traditionally been a sector in which the people providing care are happy to quietly get on with providing services, without seeking to draw attention to what they do. Sadly, that means too often social care is only in the spotlight when things go wrong.

The aim of Good Care Week is to shout about all that is good in social care, raise the profile of social care professionals, challenge negative stereotypes and champion the many thousands of heroes who provide good care across the UK every day.

During this week we want to galvanise support from across the sector to raise the profile of care at a local level. Whether it be opening up care homes to the general public, sending in good news stories to local press or writing to local MPs. We hope to build on this activity to create a strong presence across the care sector, not just during Good Care Week but 365 days of the year.

So let's get together and defy the negative perceptions of social care that the media love to portray. Let's celebrate our social care workforce without whose passion and commitment to care, quality care provision for the most vulnerable people in our communities would simply fail.

Lisa Carr
Editor, Care Talk

All eyes on June

"The detail of departmental spending plans for 2015-16 will be set at a spending review, which will be announced during the first half of next year." George Osborne, Autumn Statement, 5th December 2012. What does this mean for local government and adult social care? What should we do in response? *Asks John Jackson.* He goes on to explain why this is important and why we need to make sure that we do everything we can to respond and make the case for both adult social care and local government - and by default the NHS which relies on adult social care to make its own efficiencies in reducing acute activity.

"These discussions are private, but it is clear that the Department is listening."

Some of you may be unfamiliar with the spending review process. In essence, this is no different from any local authority coming up with a medium term financial plan that allocates resources (and savings) to individual departments.

The Government carried out a very major spending review in 2010 as soon as the coalition government was formed. The results were announced at the end of October 2010. Those plans covered the four year period 2011/12 to 2014/15 (although the Chancellor has since increased savings targets for some departments including local government).

Ordinarily, we would have expected a review during 2014 which covered the four years 2015/16 to 2018/19. However, these are extraordinary times. The political reality of having a coalition government is that they need to agree plans for 2015/16 because these must be set before the election in 2015. A new government will want to decide for itself the spending plans for later years. We have the chance to influence these decisions.

All government departments will want to consult key stakeholders especially local government where we have relevant expertise and experience. I am involved in discussions with civil servants from the Department of Health alongside the LGA and finance colleagues. These discussions are private, but it is clear that the Department is listening to the points that we are making. Our comments will be considered as the Department prepares its submission to the Treasury (although we shall not see that submission). Separately, the LGA will make a submission for local government as a whole with a particular section on adult social care. This will be a public statement of what we would like to see happen.

The ADASS Executive has started to map out its position on some of the key issues. It is clear that the position for adult social care is inextricably linked to that of local government as a whole. Adult social care has had to make savings of 7 per cent in each of the last two years (a total of £1.89 billion) because local government as a whole has had to make savings of that magnitude. Adult social care is too large a proportion of local government spending (34 per cent) to be protected.

In 2010, local government was targeted for one of the biggest reductions in funding – 28 per cent over the four years compared with 8 per cent for the public sector as a whole. Since then the reduction has increased to 33 per cent. If local government were to continue to be targeted like this (and most commentators believe that it will) then this will inevitably impact on adult social care, which according to a recent report by Skills for Care contributes an estimated £43bn to the economy.

Central Government is inevitably interested in the capacity there is to make further savings from each of the different parts of the public sector. It is implausible to suggest that there is no scope for further efficiency savings from adult social care. SCIE's recent publication, A Problem Shared - Making the Best Use of Resources, demonstrates that there is scope and no local authority can claim that they have done all of this.

However, the fact that there is scope for each of us to make some savings is not an argument that we can carry on making seven per cent savings a year like we have done over the last two years. We have considered carefully what would be a challenging but realistic assumption going forward. We think that the maximum that can be safely assumed is 3 per cent a year (which was the figure set out in the last submission). How this might be achieved will vary from local authority to local authority and some authorities will struggle more

How will benefits changes impact on social care?

than others without impacting upon frontline services.

Views on this challenging assumption are very much welcome.

"Do we need to take the Government's funding reform proposals into account now – or is that something for the next Spending Review in 2015?"

However, this is only part of the story. There is public understanding that we face exponential growing demographic pressures. While there are national estimates of what they might be, local government is at the sharp end of an understanding of what they are in practice. The ADASS budget survey in each of the last two years has shown that the impact is about three per cent a year (although not all authorities have been able to fund this pressure). So if we do make three per cent efficiency savings then this will all be used up funding the demographic pressures that we face.

There are other challenges too. Is there unmet demand out there which will increase the demographic pressures that we face? Some local authorities are already reporting that there is. A large part of the savings that we have made so far has come from holding down the prices that we pay to providers – this will not be able to continue. Indeed, many providers argue that we should be paying much more.

We can make savings by limiting the demand for care through prevention and early intervention. However, this is often only really effective if we work in a truly integrated way with health. Are individual parts of the NHS up for that and are we truly up for that? How will the changes to welfare benefits impact on adult social care (and local authorities as a whole)? Do we need to take the Government's funding reform proposals into account now – or is that something for the next Spending Review in 2015?

There is much here for us all to consider. Directors will have the chance to discuss this further at the Annual General Meeting. There is also a session immediately after the AGM to look at SCIE's Use of Resources work. We now know that the results of the Spending Review will be announced on 26th June 2013.

"This will all be used up funding the demographic pressures that we face."

At a minimum, we need the transfer of resources from the NHS to continue into 2015/16 and the best possible settlement for local government as a whole.

John Jackson
Co-Chair, ADASS Resources Network

"We have considered carefully what would be a challenging but realistic assumption going forward. We think that the maximum that can be safely assumed is 3 per cent a year."

Marshalling your energies…

Why do we think that building energy for change is such a powerful principle for healthcare transformation? Simply because when we look at the history of large scale change efforts we find that the most common reason that leaders fail to achieve their goals is because their change efforts run out of energy; they simply `fizzle out', *writes Helen Bevan.*

Helen Bevan

On the other hand, leaders who tap into the positive energy for change that exists among their people and unleash it for the benefit of achieving organisational goals typically get better outcomes. In an era of quality and cost improvement, the ability not only to build but, vitally, maintain, energy for change is a key requirement for leaders with transformational ambitions for their organisations, communities and patients.

For the past twelve months, we have been working to develop and roll out the NHS Change Model across the English National Health Service (NHS). The change model is about improving improvement across the NHS by aligning different aspects of change.

In essence, history suggests that in order to build and sustain large scale change, we need to harness intrinsic motivation for change. We need to create hope and optimism and help people feel more ready and confident to build the future. The NHS Change Model seeks to do this through connecting to shared purpose, engaging to mobilise, and leading for change.

At the same time, the experience of the NHS over the past ten years has demonstrated the importance of drivers of extrinsic motivation including transparent measurement, incentivising payment systems, effective performance management systems and holding leaders to account to deliver change outcomes. If we are going to deliver improvements at scale for our patients, all of these features also need to be part of our ongoing approach to change.

However, too often in healthcare, we haven't been able to achieve a balance between these intrinsic and extrinsic factors in our strategies for large scale change. We have overemphasised the extrinsic factors and, sometimes unintentionally, killed off the energy and creativity required to deliver improvement. So, through our work on the NHS Change Model, we are seeking ways to help leaders align these intrinsic and extrinsic factors for large scale change.

The extrinsic factors are typically much more tangible. We can describe payment, performance management and incentive systems and measure their progress and impact. When it comes to the intrinsic factors, things are much less clear. We have searched the evidence base about improving `culture for change', `organisational energy' and `organisational health'. There are multiple models and frameworks which can help. However, most of them are not written or framed specifically for a healthcare audience and most of them are proprietary tools that require a payment for use.

We decided to produce a framework that would help healthcare leaders to improve the intrinsic conditions for change and align them with extrinsic aspects. We want to make it freely available so it can be widely used. After talking to a lot of leaders, we decided that `energy for change' resonated better for our cause than other concepts. The impetus behind this project is our goal to create a simple tool for measuring energy for change at a team, organisational and/or system level.

The outcome is an instrument that enables teams to monitor their energy for change simply and effectively, coupled with a facilitation approach that enables them to have discussions and identify ways to manage this energy. Of course, the ultimate aim is to enable better, more sustainable improvements that spread more quickly. To unleash energy for change, we need to understand it.

This evidence and practice review, which included interviews with NHS staff from a range of backgrounds, reveals the existence of five energy domains as well as real-world experiences of how they are manifested in the NHS. We draw on the work of Steve Radcliffe, Tony Schwartz, Stanton Marris, Heike Bruch and Bernd Vogel, and Stephen Vogel as key contributors to the field of energy in the management literature and practitioner field. We invite you now to join us at the beginning of our journey to understand how as healthcare leaders we can become more effective in building energy for change – for the long haul.

You can find out more about the NHS Change Model at www.changemodel.nhs.uk

This article was inspired by a presentation Helen made to an ADASS policy seminar earlier this year.

Networking with the networks

It has been a year now since the Association chose to widen its membership and for the first time admit senior mangers who were not chief officers. But already many assistant and deputy directors, over the years, have made their mark on ADSS/ ADASS and on national social care policy. Here three of our newest members – on this page Lucy Butler, and opposite, Matt Bowsher and Mark Godfrey - give their perspectives on ADASS as they've found it.

I have been involved with the ADASS Mental Health Drugs and Alcohol Policy Network for over seven years, writes Lucy Butler… Roughly for the same amount of time I have been an assistant director/ deputy director. For most of that time I have acted as Network secretary.

Being part of ADASS has enabled me to get involved in debates, influence policy developments and oversee key changes in mental health, drugs and alcohol on a national level in a way that just isn't possible when you work in your local area. It's also enabled me to meet some really interesting people and Network with people on a national level. Below are just a few reasons why I think it's good to get involved in ADASS.

Changing legislation

When I first got involved in the Network the Mental Health Act (2007) was still being drafted. The Bill, as it then was, was a highly contentious piece of legislation that took nine years to gain Royal Assent. The Network worked heavily with the DH and other organisations to influence and shape the Act and also to provide additional guidance for local authorities regarding its implementation. It was fascinating to get involved in the development of the Act and also to see the 'machinery' of the DH and government play out. To be able to get involved in the debate, take an active role in consultation and work with others across the Mental Health Alliance against some of the more draconian elements of the original Bill was very exciting and satisfying.

Lucy Butler

Changing attitudes and culture

As everyone knows mental health, drug and alcohol services are usually integrated and led by provider health trusts. While the Network has always advocated integrated working in these services we were hearing concerns across the country about local authority workers (social workers and support workers) who felt left behind and neglected by the local authority. The Network published a paper outlining our concerns entitled Mental Health into the Mainstream. In it local authorities were criticised for their retreat from these services and advised to take an active role in ensuring social care outcomes were met.

I think this did have an impact: local authorities do now recognise the importance of mental health services wherever they are hosted and also recognise the importance in these areas of social care outcomes for the people that use those services. It always really pleases me when I meet people who have read the report and who say this helped them reformulate how they approached mental health services in their areas.

Partnerships

One of the great things about working with ADASS is that you are able to develop strong partnerships with some key organisations to develop policy and practice further. While I've been working at the Network I've worked with colleagues at the DH on the implementation of the Mental Capacity Act, colleagues from the NHS Confederation on joint work on personalisation in mental health and recently our Co-chair Terry Dafter has completed some fascinating work with the Royal College of Psychiatrists on pooled personal budgets in mental health.

Networking

I have had the opportunity through my work with ADASS to meet some fantastic people. You get the chance to meet regularly with senior colleagues and directors across a range of local authorities and other organisations to discuss, debate, compare notes and ultimately influence and change things.

It's a great way of building up a network across the country of people who you are connected to around a particular area. I have used the Network to check out things, ask advice on a particular issue and have even received some mentoring from a director.

You never know. One day…

I think it's really important if you are an assistant director or deputy director to get involved in ADASS. For me it's broadened the way I think about things. It's also good to work with a range of senior colleagues and directors to understand their perspectives. Although the job is essentially the same across the 152 areas - different directors work in very different ways and it's really interesting to work with a range of directors to see this and also to start to understand their perspective on life. That's important because you never know – one day you could be in their shoes.

For the future

I am planning to stay involved with ADASS and the Network. We are planning to publish a new vision statement later this year and I'd really like to be Co-chair in the future.

Lucy Butler
Secretary, Mental Health, Drugs and Alcohol Policy Network

Putting the AD into ADASS?

The extension of ADASS membership to assistant directors (ADs) is welcome, writes Matt Bowsher and Mark Godfrey. ADs are in a unique position and already make a significant contribution to the organisation through deputising for directors at branch meetings and leading/co-chairing regional networks.

Mark Godfrey

ADs are establishing relationships with both their peers and other directors across the region to apply best practice and deliver stringent efficiency targets. Our roles often span operational and strategic management so we have a means to test and refine policy and practice. We play an active role as thematic leads for subjects ranging from delayed transfers of care to personalisation to dementia care.

Our work has shaped a range of best practice, developed toolkits and case studies both regionally and in some instances nationally. We are also mindful that the portfolio of each DASS is expanding significantly and we need to continue to step up and provide support.

In the West Midlands, the assistant director network is fast approaching its first anniversary and every local authority in the region has participated. We have grappled with weighty topics like efficiency, provider sustainability, Making It Real and sector-led improvement.

Sharing what does and does not work saves time, effort and public money. Listening to others' approaches enables new thinking. Collective discussion can also enable local solutions. Sometimes hearing that no-one has an answer is both a relief and a mandate for collective action.

ADASS also provides huge developmental opportunities for ADs. Getting out and about is ever more difficult with increasing workloads and decreasing budgets. Inventing a myriad of answers to the same questions is pointless and will not ensure a consistent experience for people who use care and support services. We have an opportunity to absorb different leadership styles, learn more about the interface between ADASS, the DH and Government and the art of getting things done in a national organisation.

The challenge is that AD membership of ADASS does not become a name-only function. Capacity is as finite as resources. We can improve visibility and network nationally where fora already exist (such as spring seminar and the national conference) and also exploit new technology to network virtually.

It incumbent on ADs to demonstrate our value and commitment to the Association. We also would welcome mentoring and development opportunities from DASSs who are willing to devote their time. Those of us who do commit time and capacity to support ADASS would also like an active voice in decision making.

There is also the potential for ADs to develop their own experience and raise their national presence, and the possibility of co-leading national pieces of work is a significant step forwards.

Existing ADs may decide to apply for future DASS posts and this leadership by ADASS in extending membership gives clear recognition and direction for transition planning and ensuring resilience. This is a great opportunity, in a time of austerity with the need to think, and do things, differently and for ADASS and ADs to seize the moment.

Mark Godfrey
AD Coventry

Matt Bowser
AD Dudley

directors of adass
adult social services

WELCOME

The Association of Directors of Adult Social Services (ADASS) represents directors and senior managers of adult social services departments in English local authorities. Directors (DASSs) have statutory responsibilities for the social care of older people, adults with disabilities and adults with mental health needs.

In many authorities ADASS members will also share a number of responsibilities for the provision and/or commissioning of housing, leisure, libraries, culture, and community safety on behalf of their councils. Nearly a third of DASSs are also the statutory director of children's services for their authority.

We are pleased to welcome guests and speakers to our spring seminar at the University of Warwick as well as the many new members among our assistant directors and other colleagues who will be attending this event for the first time.

How the Network works…

How times and attitudes change? writes Brian Parrott. 'Oh, the Associates: that group of self promoting individuals with their various commercial consultancy interests. Be warned. Be careful.' (Early 2000s).

And,

'What would we do without the Associates Network? That range and depth of experiences, personal standing, contacts and networks which help promote the interests of people who need adult social care services and of ADASS in so many places of influence nationally, regionally and locally.' (Early 2010s)

Brian Parrott

These two extremes may caricature perceptions, views expressed, or what may have been felt but not said in my ten years or so as an Associate. (I was never sure whether during my two years as an interim director in three local authorities I was again a 'proper director', an associate or both.)

So who and what is the Associates Network in 2013? Answers please on a scale of one to 10 against the two introductory statements before you read on. Here are some possible answers:

The most long-lasting and stable, except for the executive council and trustees, part of the infrastructure of ADASS (and before that even, before the transition from ADSS)?

A place of 'discussions, debates and debacles' according to the stories which Drew Clode claims he has heard regaled over time when he asked me to write this piece for 'Futures'. 'Debacles?' Surely not. Comical incidents at my own expense I may be willing to tell.

I know Drew will never let me forget my briefing Moira Gibb a decade ago from Moscow airport just before a Newsnight appearance, while just still resources committee chair. Incidents involving other colleagues I would not betray. Perhaps though for the Spring Seminar or Annual Conference bar… I'm sure a drink would encourage…

Perhaps a genteel home for voluntary and forcibly retired directors who variously 'made it', 'made it but then became unstuck' or 'never made it and should not have been appointed in the first place'? Drinking and dining together periodically but with little of substance or current relevance to talk about except wearisome tales of their alleged glorious pasts.

The place for energetic, philosophical and policy debate about new and emerging public policy matters, ranging across social care (children as well as adults, because several of us never accepted the separation), health, housing, welfare, criminal justice, international perspectives and more. Debates stimulated by leaders within our own network – Herbert Laming, Denise Platt, Julie Jones, Andrew Cozens, Oliver Mills, Roy Taylor, Vic Citarella, Paul Snell and, of course, my media celebrity Co-Chair, Richard Humphries, as well as each of the Presidents in turn, Sarah Pickup most recently.

'If only they listened to the likes of us' we periodically wail. Then we check round the table at the fingers in various policy and influencing pies. We reflect that it's not about being heard, it's the willingness to be listened to and having impact.

A behind-the-scenes network which operates in at least three different ways? Firstly, some of our members from among the current 141, not to mention names, who, semi-detached from ADASS President's Team, are able to open doors, have conversations which don't happen, and sometimes to set up useful opportunities for ADASS to have influence with people and in places which matter.

Secondly, providing confidential contact, suggestion, link or counsel between individual associates and between an associate and a director, perhaps a director who may shortly become an associate.

Thirdly, advising those associates who wish about requests from individual directors wanting someone to do a piece of work, without directors needing to approach expensive commercial companies.

So what is your answer to the question at the beginning of this piece now? Merely self-interested individuals or a body within ADASS of value to the Association and its members?

I wouldn't want to finish this piece without identifying why, of course, the Associates Network is so successful. Two reasons: Cathie Williams for the last six years and Jennifer Bernard before that.

Any successful organisation needs a hard-working, well-connected and well liked person as its Honorary Secretary. Cathie's agreement in blood to continue for at least a further three years as Secretary was required before Richard Humphries and I agreed to stand for re-election as Co-Chairs for a second term in 2011. Her work for the Associates Network and with others in ADASS is simply huge and I know much valued by colleagues.

Also, without Cathie, Richard and I would not be able have the fun we have as Co-Chairs.

Brian Parrott
Co-Chair, ADASS Associates Network

A Daunting responsibility

The new Chair of TCSW, Jo Cleary knows that it sounds like a cliché. But it really is a once-in-a-lifetime opportunity for social workers and social work to have their own College. Every other profession has one except ours. She has been asked, and she has asked herself, the question: "Why not?" The answer always comes back to "Do we value ourselves as a profession?"

Jo Cleary

I believe it's our time. It's our time to stand up for the contribution of social work and social workers, particularly as families, vulnerable people and communities are struggling in this harsh economic climate.

So many of the social workers I know are highly committed, caring and compassionate professionals, totally determined to do their best for the people they work with. They demonstrate these qualities, not because of the pay or because the work conditions are always ideal – important though these factors are – but because they believe passionately in what they do and why it matters so much, and always aspire to be even better at it.

I am a social worker by training myself and I know what it takes to be a good one - how knowledgeable, resilient and perceptive you need to be. It is a hard-won skill which requires constant development and attention to new evidence and research. That is why I am becoming the first Board Chair of The College of Social Work - the centre of excellence in social work, which is being set up along similar lines to the royal medical Colleges.

The first thing to emphasise is that we will be a thoroughly democratic professional College. This year we have taken our first steps on the road to democracy with half of the social worker positions on our governing Board and our Professional Assembly up for election by The College membership. By 2016 all of these positions will be elected and I am entirely committed to The College of Social Work being a democratic body fully accountable to our members.

But our commitment to democracy goes deeper still. Our members are encouraged to play an active part in the work of The College, whether as professional mentors, policy champions or media spokespeople. Our social workers are getting their voices heard in all sorts of ways. And we will support and develop social workers to take on future Board level posts.

The College's professional practice resources are changing the landscape of social worker training and career development. Our Professional Capabilities Framework is for the first time providing a set of professional standards which provide a clear pathway for improving social work practice by setting out clearly what skills and capabilities social workers need to harness at every stage of our careers. Our e-Portfolio and accompanying CPD resources make it easier to achieve the high standards set by The College, employers and the regulator, the Health and Care Professions Council.

For this reason we have been keen to promote our Corporate Membership Offer to local authority directors, inviting you to purchase College membership on behalf of your social workers, as well as non-social work qualified staff where helpful. You want your social workers to be the best and so do we. You and we have a common interest in the professional development of our members.

Like other professional Colleges we have an important role in influencing policy on social work, both at national and at local level. Here, the challenges of the year ahead are evident. The Children and Families Bill, which incorporates the government's plans for adoption, has significant implications for social workers and The College will ensure through its parliamentary work that our voice is heard as the Bill progresses.

Our Children's, Adults' and Mental Health Faculties enable us to harness the expertise of our members to shape policies in the interests of social workers and the people who use services. For example, our children's faculty chaired by Eileen Munro has monitored implementation of her child protection reforms and is helping to inform our thinking on policy and practice.

At the same time the old verities of social work with adults can no longer be relied on. Last year's Caring for Our Future White Paper said "social workers have a crucial role to play in the reformed care and support system." We agree, and our Business Case for Social Work with Adults is an evolving programme that seeks to show why social work has a "crucial role to play" in new-look adult social care, what its role is, and why it has both social and economic value.

Social work has a unique opportunity to take charge of its destiny. Like the doctors who belong to the royal medical Colleges, social workers through their new, professional College have a chance at last to set the terms of their engagement with service users rather than have others do it for them. I will not let it go to waste.

I am very fortunate that Lambeth Council has agreed that I can take a flexi-retirement basis from April, to give me the space to take on this new role. But I need your help as well. As leaders, please take up our corporate offer and encourage your social workers to participate in the activities of the College. The social work practice in your council can only improve as a consequence.

Jo Cleary *is Honorary Treasurer and Company Secretary of ADASS, Executive Director, Adults' and Community Services, London Borough of Lambeth, Chair of the National Skills Academy and of TCSW*

Making growing old as good as growing up

SINCE CEASING TO be director of adult care nearly four years ago I have had the benefit of various pieces of surgery to counteract the ageing process (and I don't mean cosmetic surgery). As with so many aspects of being a Baby Boomer I think I am very fortunate to have been one of that cohort and to have had the care of the NHS throughout my life. How much those directors who are yet to retire will similarly benefit is - like their salaries and pensions - open to some uncertainty. It will be linked to what the country can afford and hopefully decided by wise, elected politicians rather than a few newspaper owners.

I know that the work we did as social workers and as managers was paid for by a state which recognised that not all people could protect and care for themselves and that `social services' were needed. During my career we discovered `child abuse, and because of our success - and sometimes learning from our failures - countless children's lives were made better.

The fact that we still have so many children needing protection is a national failure to produce good enough parents which must partly explain some still undetected and untreated abuse

Now I have more time to focus on getting old I cannot avoid wondering if this is as good a country to grow old in as it was to grow up in. The struggle to address the issue of funding adult care seems at odds with the massive resources that were poured into child protection. I do not feel that we have the same approach to caring for vulnerable older people as we do for vulnerable children. I am now Chair of a small charity called Action on Elder Abuse (AEA). We are now in our twentieth year and we have had a considerable impact on the way in which elder abuse is identified and responded to. But you could hardly call us a household name.

Research indicates that there are perhaps half a million incidents of elder abuse a year, so much of it in places or from people who are supposed to provide care. I know that there is still much to do to get the attention of the public, politicians and media to say that this is totally unacceptable. We all have the benefit of many years of extra life provided by the Welfare State. But if we see those years as a problem best ignored then when our time comes it may be too late to say. Why do we see older people as unworthy of respect and care.

We don't beat children anymore and condemn those who do. Neither do we think they should be stolen from or subject to emotional or sexual abuse. However, when this happens to older people it rarely makes the headlines or keeps our attention.

The NSPCC raises £136M a year to fight the abuse of children but AEA struggles to get £0.5 Million to carry out a comparable task. Fifty people are sponsoring the NSPCC in the London Marathon: AEA has just one kind runner. This is not a fundraising article, although our website will tell you how to help us. Rather, it is to highlight the gross difference in the way we see the protection of children and of older people.

Baby boomers and those of you who currently carry on the vital work of making this country a good place to grow up in and a good place to grow in must also work to make it a better place to grow old in.

Dr John Beer OBE
Chair of AEA and former Honorary Secretary, ADASS

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