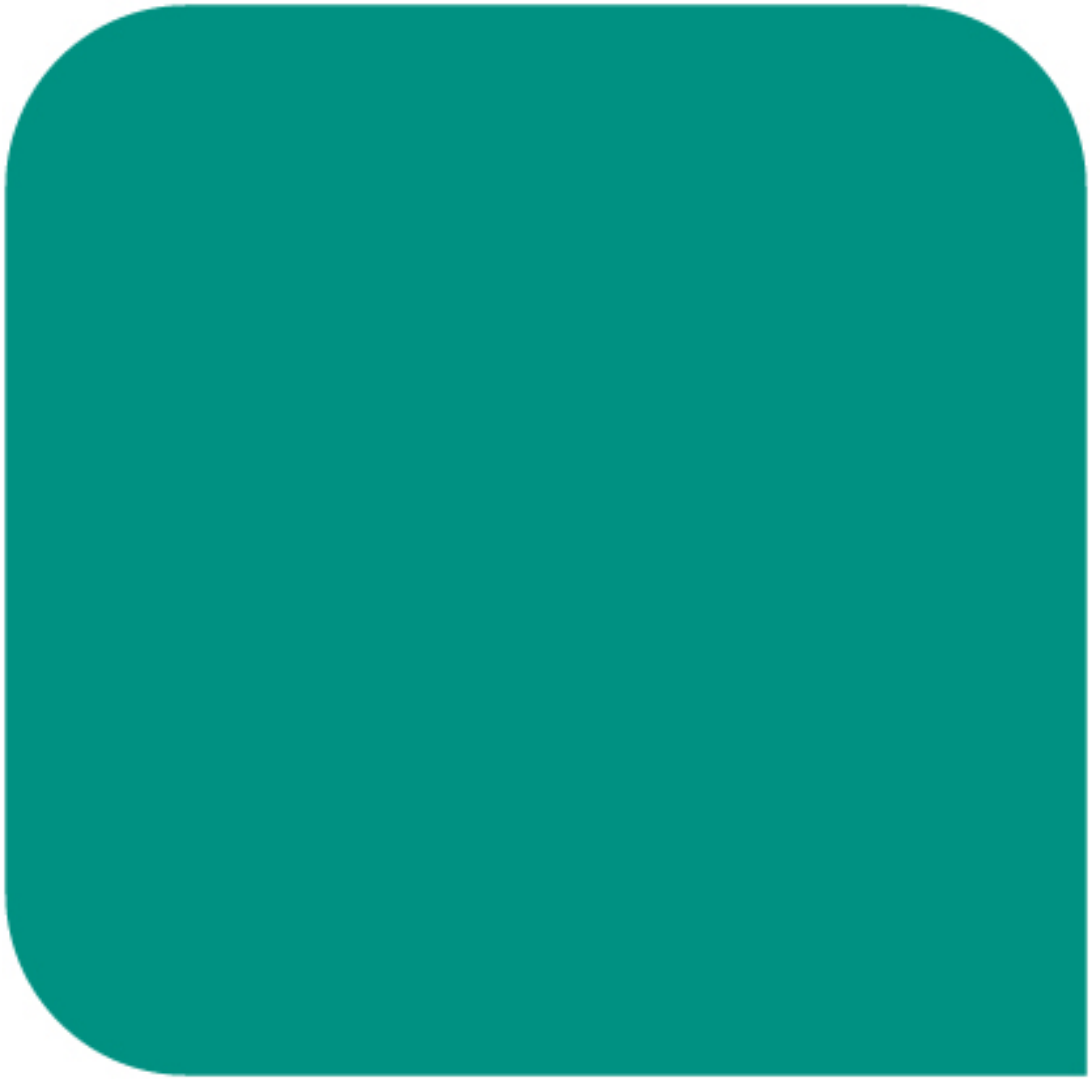
social care
institute for excellence

SCIE roundtable discussions:
New perspectives on the future of care and support

Leading the Care Act



The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works.

We are a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK. We also work closely with related services such as health care and housing.

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

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

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‘I don’t want you to use your leadership and power to manage people, resources and properties. I want you to use your leadership to make good things happen, and to stop bad things from happening.’

Larry Gardiner, member of SCIE Co-production Network and resident of sheltered housing

SCIE roundtables

In early 2015, SCIE arranged a series of roundtable discussions exploring how to improve care and support at a time of growing demand, demographic change and financial constraint.

These sessions covered:

- Community-led care and support
- Leading the Care Act
- Health and Wellbeing Board (jointly with The King’s Fund)
- Social care and technology (jointly with the Department of Health)

This is the report from the discussion on leading the Care Act.

Introduction by Lord Michael Bichard, Chair, SCIE

'We need to move from a leadership model where people say "My organisation is the only thing that matters"; to a leadership model that understands the importance of wider outcomes – and in particular the outcomes for people who use our services.'

Lord Michael Bichard
Chair, SCIE

The Care Act is a bold piece of legislation not least in terms of its intent to place power in the hands of users and carers. But it will be judged not by its intent, but by what it delivers; and that to some extent is going to be dependent on the capacity of leaders to respond.

We are facing some major challenges if we are going to move from the traditional model of leadership to the kind of leadership that the Care Act demands. In the past, it has often been about building the reputation and scope of single organisations, and the way we have fragmented government in the past has played to that agenda.

If we are honest, leaders have sometimes pursued the agenda of their own organisations so enthusiastically that they have not taken account of the consequences of their actions and their effect on others who are seeking to work in the sector. We need to move from a leadership model where people say: 'My organisation is the only thing that matters'; to a leadership model that understands the importance of wider outcomes – and in particular the outcomes for people who use our services.

Leaders in the statutory sector have been too slow to understand the value of the voluntary sector. They do not always understand it and sometimes they have treated the voluntary sector with scant regard. We have all also been slow to develop the kinds of skills that we need in the future: the skills to build sustainable coalitions, to design services around clients, to commission and procure, and to win ownerships across a shared community. Regulators have not always focused strongly enough on how organisations have or have not worked well together to deliver services.

The kind of change required takes real courage for leaders to look beyond their organisation. Loyalty towards our own organisations is not more important that loyalty towards the client. Leaders need to be honest and self-critical if we are to adapt to the aspirations set out in the Care Act.

The Care Act is the most ambitious set of reforms to care and support services since the Beveridge Report (1946), and will require skilled, resilient and committed leadership at all levels of the health and social care system. This roundtable will explore the kind of leadership we need to make the Care Act a success.

Key messages

A number of key messages emerged from the discussion, which we have grouped under the following headings:

Challenges and opportunities

1. Demographic changes, funding challenges and increasing demand all imply that we cannot plan, commission or deliver care and support in the same way as we have in the past.
2. Delivering joined-up care is also complex in a fragmented, increasingly pluralistic system with multiple players
3. Preventative approaches require looking at the system more broadly than just health and social care to include, for example, transport, leisure and employment services.
4. There are vested interests that will challenge the need to share power with different parts of the system – including with people who use services and carers.
5. Policy-makers seem to start with a top-down approach, and then as their term in office comes to an end, they realise it does not work. We have to start with a bottom up approach.

'When there was more money, people weren't happy with the service they received then either. I kind of dread the world when there would be loads and loads of money because we would be even more "done too"!'

Sue Bott CBE, Deputy Chief Executive, Disability Rights UK

The role of leadership

6. Leadership is about making good things happen, not just meeting management targets or providing a service defined in the organisations' own terms.
7. It is the job of leaders to make the complex, simple. Whilst we all need to draw upon management theory and practice, it is not as important as providing a high-quality service to individuals and we should try to avoid using unnecessary jargon.
8. Leadership is about co-production, not command and control. Leaders should be willing to take a risk, step back and share that power with people who use services, not just consult on it.
9. Leaders across the system need to agree between them what outcomes they are trying to achieve for communities, and then align resources and activities to deliver these outcomes. We need to ask: What is the right outcome for the person? And then use this as the starting point for commissioning and planning.
10. The leadership role should be about setting a culture that accepts it is not all going to be perfect and that accepts that in order to improve outcomes, learning will have to take place across the whole system.
11. Political leaders need to set clear policy priorities and outcomes, and to align local leaders so that change can happen at local level
12. Regulators are taking the lead in emphasising the importance of organisations being well led and well coordinated, with other parts of the care and support system.

‘The challenges for us as leaders are to: ensure everyone is clear about the value base of the organisation, develop an open culture, be clear that we are all there to deliver outcomes to citizens, and to encourage everyone to understand their role in delivering those outcomes.’

Professor Martin Green, Chief Executive, Care England

Systems leadership at all levels

13. The biggest single indicator of quality in any service is the quality of the first line manager and registered manager – they are probably the most significant leaders in the system.
14. The system does not work if we do not have strong leaders who are service users and carers.
15. Health and wellbeing boards show how accountability can be shared and also show that no one organisation can solve any issue alone. A range of organisations need to be involved in leading change across the whole system.
16. We need to consider the context in which the system works. Too often we see the system as ‘receivers’ and ‘givers’ rather than about mutuality and the contribution that comes from everybody.
17. Integration is not about structures and organisational change; it is about building the cultures and supportive behaviours that ensure services work seamlessly together for the benefit of people who use services.
18. We need to engage all levels of staff in the concept of personalisation and co-production – not just senior leaders.
19. Systems leadership needs to be complemented with practice leadership, including supporting newly qualified staff to become the leaders of the future.
20. The way we finance and commission services needs to be reconsidered. It can lead to the squeezing out of niche, small and local providers.
21. We need to look at how we use volunteers and how we citizens can support themselves.

‘If we combine lay people having a powerful voice, politicians having more discretion to do things differently, and a need to renegotiate the deal about care with the public, we will be able to meet some of the aspirations of the Care Act. It will need us, however, to manage that process together.’

Andrew Webster, Associate Director, Integrated Care, Local Government Association

Co-production with people who use services and carers

22. There is a business model basis for co-production. It can save money and can support the design of seamless systems of care and support.
23. Each organisation in health and social care should develop the leadership of the people who use services. It is a free resource, but you need to invest to begin with in building the skills, confidence and capabilities of people who use services.

‘The biggest difference was having lay people at the table… Managers and professionals couldn’t misbehave if there were lay people at the table. The second thing was having all the money available on the table as well.’

***Andrew Webster*, *Associate Director, Integrated Care,* LGA**

Leadership styles, skills and values

24. We need distributive model of leadership throughout different levels of the system, rather than a model that is reliant on having a small number of charismatic leaders.
25. Leaders need to be good at managing and leading strategic and cultural change. It is good leadership that makes the difference – not just developments like pooled budgets or better IT systems.
26. Leaders need to be authentic about who they are and the values they hold.
27. We need to go back to base values when we are considering the role of leaders. Different organisations’ targets may conflict, but many leaders in the health and care sectors share the same values.

‘We need to move away from this pompous vision of ourselves as leaders. We talk about cultural change, but we always think it’s others that need to change, not us. Do we, as leaders, really know if we are contributing to or impeding the success of our organisations? Good leaders know when to give up their roles and their power.’

Tony Hunter, Chief Executive, Social Care Institute for Excellence (SCIE)

Presentations

Baroness Sally Greengross

Cross-bench Peer, House of Lords

‘All the leaders involved need a huge amount of support if we are to get the aims of the Care Act delivered.’

Baroness Greengross is a cross-bench Peer and Chief Executive of the International Longevity Centre UK. She was Director General of Age Concern England from 1987 until 2000; also until 2000, she was joint-Chair of the Age Concern Institute of Gerontology at King's College London, and Secretary General of Eurolink Age.

Economist Andrew Dilnot envisaged a system where long-term care insurance would be available to support the delivery of many of the services set out in the Care Act. But we do not have that funding available. We do, however, have leaders who are still responsible for providing services as outlined in the Care Act.

And we now have large numbers of people with multiple long-term needs. It is difficult for the leaders who are providing care to get it right. I do think staff and leaders will need a tremendous level of support to do this – a lot of the information that SCIE produces is going to be essential to getting this right.

The new duties on local authorities are going to be very challenging. For example, people who would normally never go near social services are now going to register on the ‘meter’ so that they can build up towards the cap on care costs. This means local authorities will have many more people to support and advice. How are local authority leaders going to manage this and get it right?

The assessment of carers is another area where people will need training to do it properly. Carers have long-term needs as well. It’s fine to say carers have a right to an assessment. I would be very cross if I was told I had a right to an assessment and was then told that I could not be supported.

Prevention runs throughout the Care Act, but there is little money for this. If serious acute needs come first as they will do when resources are scarce, then how will anyone get preventative care? We need to get in much earlier and turn this around. SCIE has a Prevention Library – but how can we get it used to really transform people’s lives so we get that preventative approach in place?

The current drive to join health and social care budgets – and responsibilities – is essential and long overdue. We must integrate health and social care. I am very interested to see what will happen in Greater Manchester to see if the services improve care when changes occur there. I sat on the Barker Commission on the Future of Health and Social Care in England and we thought that perhaps joining up should happen at the health and wellbeing board level, not the clinical commissioning group (CCG) level. We know there can be a professional jealousy between health and social care professionals. If integration is at CCG level, the risk is that the health sector will continue to dominate.

David Pearson

President, Association of Directors of Adult Social Services (ADASS)

'If you want to influence change, then you need to be authentic about who you are and the values you hold.'

ADASS is a charity that aims to further the interests of people in need of social care by promoting high standards of social care services and influencing the development of social care legislation and policy. The membership is drawn from serving directors of adult social care employed by local authorities. Associate members are past directors and our wider membership includes deputy and assistant directors.

There are different layers to leadership of the Care Act: there are national leaders, local leaders, and those who deliver on the ground. And we know that the biggest single indicator of good quality, in any service, is the quality of the leadership of the first line manager.

The Care Act happens in a broader context. And while I will only mention it once, austerity is a big deal. There is the 26 per cent (£3.5 billion) reduction in funding over the last four years, combined with ADASS and the Local Government Association's analysis that, if nothing is done to prevent it, there will be a £4.3 billion gap between now and 2020. That goes alongside the NHS's £8 billion gap identified by Simon Stevens, the Chief Executive of NHS England, which assumes that there is sustainable social services in place with no more cuts.

We have challenges because of the increasing pluralism in health and social care organisations with 25,000 care settings, foundation trusts, CCGs, NHS England, Monitor, Trust Development Authority and so on.

At a local level, health and wellbeing boards show that accountability can be shared. This also emphasises that there is no one organisation that can solve any issue – it has to be a range of organisations. That has a huge impact on the leadership that we exercise.

The fact that the Department of Health and local authorities have been brought together to deliver the broader goals of the Care Act, shows how you can put aside different organisational priorities for the greater good. The Department does not control local authorities, but they have been dependent on us to deliver the Act. The Care Act is grounded on three principles: wellbeing, integration and personalisation, as it enshrines, in legislation, the idea of personal budgets based on people's needs.

We are only as good as our weakest link, as well as being much greater than the sum of our parts. A Demos report on the future of residential care reveals that 54 per cent of

people do not want to go into residential care because they think that they will be abused or neglected. It is actually two per cent of the population in residential care that are abused or neglected. Two per cent too many, 7,000 very bad stories too many. But the emphasis here is that we are all ambassadors to the public (in a very transparent world) for the quality of what we are doing; and we therefore all have to take responsibility. Leadership is spread right throughout the system.

I think it is the job of leaders to make the complex, simple. What is important in the Care Act is advice and information, prevention and early intervention. There is not enough money for this, but we do need to join it up with other public services – health, public health and housing – at a local level. From a leadership point of view we have to paint a picture and sell a vision: that people's needs are not just dealt with by departments.

If we think about people with multiple long-term conditions, the health service is built on episodic care, which can be fragmented. We need experts, but it does not work for people with multiple long-term conditions and can be impersonal. We need continuous, personalised, long-term care. And what does social care do? It does continuous, joined-up, person-centred care.

We need to build community capacity so that we have fantastically resilient communities and families that create the environment we want to live in and that are sensitive to the needs of those with long-term conditions.

This is probably one of the most challenging times to be a public sector leader. It is also a time of fantastic opportunity for creativity and for influencing the future. We need our leaders in government to set clear policy priorities, be clear about the outcomes that are expected and to align leaders so that change can happen at local level. Too frequently that's not the case. We can get confused between what is a national initiative and what is national management of the system. There has to be devolution but there also has to be national oversight.

We have responded well and it is extraordinary what has been achieved if you think about the context of increasing need and reducing budget. There is no ground for complacency, but it shows the kind of ingenuity that can be developed.

Leaders need to be good at managing and leading strategic change. All the evidence suggests that it is leadership – not developments like pooled budgets – that make the difference. Leaders need to understand management, money and quality – and sometimes we have forgotten the quality dimension.

If you want to influence change, then you need to be authentic about who you are and the values you hold. It is very important. If you think about how you make people want to aspire to greatness, you don't hammer them about what they haven't done. As Care Quality Commission Chief Executive David Behan says, people thrive in high-challenge, high-support environments. The risk is that we focus on the high challenge – we sometimes miss the support element of the equation.

We need to be responsible for our own improvement and to be open to challenge. We need to be clear about what we are trying to build – is it charismatic leadership, or

distributive leadership where we are trying to build leadership across the whole system? The social care system does not work if we do not have strong leaders who are service users and carers. We therefore need to ensure that people are supported and enabled to exercise that leadership.

Professor Martin Green

Chief Executive, Care England

'I've never heard a service user say to me "My real concern is the management structure". What they are concerned about is the delivery of the service.'

Care England is a representative body for independent care services in England. Membership includes organisations of varying types and sizes, including single care homes, small local groups, national providers and not-for-profit voluntary organisations and associations. Between them they provide a variety of services for older people and those with long-term conditions, learning disabilities or mental health problems.

The Care Act is less than perfect, but what legislation is ever perfect? The challenge for any system is not to analyse the minutiae of what is wrong but to use what we have got as the facilitator for improvement and development in the system.

The budget position, demographic change, and people's changing aspirations, all tell us that we cannot do what we have always done. This is a moment when we have got to think differently and enter a paradigm shift about how we facilitate and support people to have good quality lives.

Systems work in a context and we should consider that context whenever we think about how we manage and lead a new approach to care and support. It is about prevention, it is about how we engage communities at the start, to not only to think about what they want, but to remind us that they contribute. Too often we see our whole system as being about 'receivers' and 'givers' rather than about mutuality and the contribution which comes from everybody.

One of our systems leadership challenges is that we are also managers, and sometimes the targets we have conflict with each other. We should go back to the base values of what health and social care is about. We should recognise that our managerial responsibilities may sometimes impede our ability to have a whole-systems approach. Our managerial objectives might be different, but our values across health and social care are very much the same. Let's build our relationships and our approach on leading a system on the values that we share, and work from there

I think there is a huge need for massive culture change. We need to think strategically about how we get to a point where we understand the cultures of our organisation, and then make them more open and accepting of other parts of the system. If we had spent one-tenth of the funding for re-organisation on cultural change, we may have got further.

Too often we get hung up on integrating structures or joint appointments. We should remember that people who use services don't care if the back offices are integrated or not – what they care about is their experience. Many things we do – such as online shopping – involve a range of organisations working together to provide a seamless system. As leaders, we need to focus on that seamless experience for the person who uses the service.

There is little or no understanding of approaches to power. Wherever you are in the organisation, you have power – be it structural power, the power of knowledge or the power of influence. The challenges for us as leaders are to: ensure everyone is clear about the value-base of the organisation; develop an open culture; be clear that we are all there to deliver outcomes to citizens; and to encourage everyone to understand their role in delivering those outcomes.

It is tough, particularly in a system that is very good at criticising you when you get it wrong. We need to change the culture from a system that is risk-averse, to one that is risk-aware. Any system that is not taking risks is a system that is not innovating, developing or changing to suit changing needs. The temptation is to point the finger when things go wrong in other parts of the system. But we need to support people in the bad times as well as the good.

The system is broad and we should try to encourage innovation. Care providers need to respond to changing needs. If a source of funding, such as a local authority contract, dries up, companies have to develop a diversified business model or they may go bankrupt. One Care England private sector provider worked in partnership with voluntary sector organisations, residents and families, transformed their business and delivered a range of services that had never been available in that community before.

I've never heard a service user say to me: 'My real concern is the management structure.' What they are concerned about is the delivery of the service. As system leaders we cannot look through blinkers, we need to see the whole of the picture and consider who can support us to deliver an integrated, high-quality system that delivers high-quality life. It is an extremely tough call. We have to give ourselves space to think creatively and to harness the creativity that is out there.

Sharon Allen

Chief Executive, Skills for Care and The National Skills Academy for Social Care

'Systems leadership is needed at every level because the definition of wellbeing in the Care Act goes well beyond social care and health – it talks about work, education, recreation and housing. Can any one of us say that we can, on our own, address all of those needs? We need to work together, recognising each other's responsibilities.'

Skills for Care is the employer-led workforce development body for adult social care in England. Home of the National Skills Academy for Social Care, they offer workforce learning and development support and practical resources from entry level through to those in leadership and management roles.

The development of the original Care Bill was a good example of systems leadership and co-production. We now need both of those elements to deliver on the Care Act.

Systems leadership is needed at every level because the definition of wellbeing in the Care Act goes well beyond social care and health – it talks about work, education, recreation and housing. Can any one of us say that we can, on our own, address all of those needs? We need to work together, recognising each other's responsibilities.

It is fantastic that we have legislation that talks about personalisation. It will become common parlance, but it also has to translate into what we actually do. It means we need to engage all parts of the system in this language. There is no point in strategic leads using 'personalisation' and 'co-production'. Social workers, care staff, occupational therapists and others – they need to understand what we are trying to get at. At present we are not engaging them in the programme.

Systems leadership runs through The Skills Academy programmes. It is about relationships, working across the sector and bringing about the change we need to see. Most care providers are in the private sector. I joined Skills for Care from the voluntary sector and I acknowledge I had a particular view of the private sector – and that view has changed. A willingness to develop your perspective is an important part of systems leadership. Some of the sectoral arguments get in the way – we need to focus on the values of organisations and what we are trying to achieve.

Skills for Care has a range of services and guides to support Care Act leadership and implementation, including on workforce capacity planning, modelling and a readiness tool on workforce integration. We are currently developing a guide on commissioning and co-production.

How are we going to get to that place where people have one person who is responsible for coordinating their care and support, bringing in expertise as required?

We are facing some very real challenges. Local authorities are more confident about their ability to implement the Act, but there are still challenges around funding and capacity – particularly for carrying out assessments. When the pressure starts to come, the risk is that people retrench to their positions. We need to look at the resilience of people to deliver on the Care Act. As leaders, we need consider what support we can give to people, including saying that we know it is challenging.

If we get social care providers and commissioners to come together they can develop new solutions. For example, we brought in community nursing staff to work alongside a care home and to skill-up care staff to take on roles that nurses would traditionally have done. It reduced hospital admissions, improved staff morale by developing new skills, and saved £250,000 across the services. Unfortunately some ideas are not scaled-up because we suffer from the 'not invented here' syndrome. We have to move beyond this to focus on what will improve care for citizens – not on whether it matters to me, my organisation or my sector.

Systems leadership has to be complemented with practice leadership. We need to support newly-qualify social workers to learn and to become the new leaders of the future. Registered managers are critical to success – they can give you confidence in a service, or they can keep you awake every night with worry.

Key questions for us to consider are: how do you achieve change in that iterative, inclusive way, that takes people with you through cultural change? How do we include people, ask for their ideas, and have mature conversations?

As Jon Rouse, the Director General for Social Care at the Department of Health, has said, there is a risk that we will hit the target, but miss the point of the Care Act. In order to ensure we hit both, we need to embrace and embed the cultural change called for within the Act.

The quality of learning and development is also important, so we need to screen out poor quality.

We also need to have a better dialogue with health. We have been so focused on local authorities' duties within the Care Act – but we need to engage with everyone. The focus has to be about quality outcomes for citizens, which means system and practice leadership at every level.

Views from the roundtable

‘The integration between health and social care needs much more dialogue. It will require culture change, recognising the difference between meeting the needs of the whole person versus different body parts. Given that the NHS is increasingly having to deal with co-morbidities, it has much to learn from social care, which has always taken a more holistic approach. In supporting integration it will be necessary for leaders to recognise and manage the polarities that can exist between the health and the social care sectors. For example how outcomes are defined, the health sector can be preoccupied with externally defined measures and scores, rather than asking: “Can this person do what they want to do in their daily life?” The Health Foundation is advocating the shift in health from “what's the matter?” to “what matters to you?” and we want to support people to achieve the outcomes that are important to them. Leaders and practitioners across the health and social care sectors can also take very different perspectives on risk. For example, health practitioners worry if it is safe to discharge someone from hospital even when they are medically fit for discharge, it can find it hard to accept the reality of people's day-to-day life. Healthcare sometimes tries to cosset people from bad news and not share health information with them in a timely way, we need to start to accept that people deal with all sorts of dilemmas in their day-to-day life and diagnose and prognoses are no different. Finally, there is something about visibility of 'failure' in the different sectors. For example, what do we mean by urgent care? Helping someone to get up and dressed in the morning is urgent, but is not as visible as, for example A&E waiting times targets. This can distort attention and local priorities.’

Jo Bibby, Director of Strategy, Health Foundation

‘Most of the things that have happened to me in the last five years will probably happen to most of the people in this room. And remember, I employ you all. The money I have contributed over the years pays your salaries. I don’t want you to use your leadership and power to manage people, resources and properties. I want you to use your leadership to make good things happen, and to stop bad things from happening.

’In terms of making “bricks out of straw”, people like me, and the care givers who look after me are the experts, because we don’t have the resources that you have. What I want from leaders is a vision for making good things happen and to involve people who use services and care givers in the co-production effort; because there is a business model in it. There is a shortage of money but there is a business model basis for co-production. I think it can be demonstrated that for every £1 spent on co-production, you get a £10 bonus. If you fill every forum like this with people who use services, I can tell you how to save money, I can tell you how a seamless experience of care will benefit me, and I can help you do the service-design job. And you don’t have to pay me – I am a free resource.

‘Some risks need to be taken, because the consequences of not taking those risks can really prejudice safety and wellbeing. There will be no innovation without taking risks. The people who can tell you how to contain the risks, are the people who experience

them. Each of your organisations should develop the leadership of the people who use your services, including developing a wave of future leaders.'

Larry Gardiner, member of SCIE Co-production Network, resident of sheltered housing scheme and personal budget user:

'We have to change fundamentally the way we provide and fund public services. This is not a brief period of austerity. The Care Act provides some key levers to do this. The way we go about financing and commissioning services needs to be rethought. The trend has been to "go to scale", which can lead to the squeezing out of niche and small, local providers - and polarity in the system. If they accept too much risk from prime contractors, they can go bust. We need to acknowledge the importance of social value in introducing new criteria for assessing services; and to reassess if the funding models that we have, which have driven grants out of the system, have overestimated the extent to which social investment can make a significant contribution.

'An important element is using volunteers in a structured way. This can be part of the co-production vision. NCVO is currently looking at the use of volunteers in statutory, voluntary and private sector. We are not thinking seriously enough about volunteers and volunteer management in the system. Voluntary action is part of the mix. But this approach is not always trusted by statutory services, and there are ideological barriers.

'Is there scope for the development of new mutual solutions? For example, the Dartington Hall Trust is developing a project with "younger older people" providing support to "older older people". We need to return to some of the solutions that predate our Fabian-style welfare state. There are some risks, but nevertheless we need to look at how citizens used to start to organise themselves prior to top-down solutions. That is a challenge, but we cannot continue to do things the way we have because we simply won't have the money available to pay for the services that are needed.'

Stuart Etherington, Chief Executive, National Council for Voluntary Organisations (NCVO)

We have been working closely with Community Services Volunteers and TLAP and there has been a great deal of enthusiasm for this. I don't buy that statutory services are not interested in working with volunteers. There is a rich pasture of people interested in doing this, but we need to join up the dots. The leadership challenge is for us to find our way through this. Unless we collaborate on these things, it won't happen.'

David Pearson, President, ADASS

'We need to think about getting outcomes right and then aligned more closely. For example, a CCG tightened their criteria around hearing aid provision, so that for the first time since 1948 many people will not get a free hearing aid on the NHS. It is such a cost-effective intervention – less than £400 over three to five years which doesn't buy you much social care. This is because of the narrow medical definition of outcomes. It can have a massive impact in terms of social care outcomes. We need to ask: "What is the right outcome with the person at the centre?" The direction of travel is right, and the

Care Act supports this, but we have a real leadership responsibility to put the individual at the centre.

‘We make very active use of volunteers. But we can get ourselves into invidious situations where the use of volunteers can create a downward pressure on funding. If volunteers are providing a safe haven of services, can we therefore chip away at the statutory provision being offered? So we can actually underuse volunteers as we end up using them as a value-added service rather than integrating them into the whole as a provider. We need to think about avoiding creating unintended consequences through the commissioning framework.’

Paul Breckell, Chief Executive, Action on Hearing Loss

‘What we should be about is leadership and making good things happen. Integration is not about organisational or structural change. It is about person-centred, coordinated care and ensuring that systems and services work together to deliver on that, in co-production with people who use services and carers. Because when we get it right, we can transform people’s lives. But when we get it wrong, it can be awful.

‘I’ve met with families whose relatives died at the Orchid View care home. Their continuing concern is about people falling through the gaps when organisations fail to work well together.

‘As the regulator we can be clear about the expectations that we are setting. We have to monitor against that and share findings in a way that is helpful and that encourages improvement. On leadership, we need to make clear how important it is. It is one of our five key questions that we ask of every service; that is, is it well led? The kind of leadership that we are looking for is open, transparent, inclusive and generates a culture that values and empowers people who use services, carers and staff. It focuses on outcomes. Our early findings show that there are two questions that we see weakest performance on. One is safety and one is on the question of whether services are well led. So, we have a lot more to do on strengthening the leadership and particularly on peer support for registered managers.

‘We are also ill served at the moment over graduate leadership training – we have had it in the NHS for years, but only for four or five years in social care.

‘On integration, we will still need to focus on the quality of individual organisations, for example when looking for a care home. But we also expect those individual services to show how they work with others in a more systematic way. CQC asks this across all the sectors we work in.

‘We can also look at thematic reviews such as Cracks in the Pathway, which looked at the effect on people who are living in care homes with dementia and their journey between hospitals and care homes. There were many of examples of good care, but there were also some real gaps – not least around communication and information sharing.

‘We can also look at the experiences of people in localities, by bringing together the information that we have to look at the whole system; and consider what is it like, for example, for someone with dementia to live in any particular area?

‘Regarding volunteering we are also looking at how open the culture of a care service is – such as whether they are using volunteers and are open to the community.’

Andrea Sutcliffe, Chief Inspector of Adult Social Care, Care Quality Commission (CQC)

‘The biggest single change in the workforce in adult social care is the growth of full-time carers. The last census showed this dramatic shift. It is fascinating that we call them ”informal” carers. We would never call parents ”informal” parents! We need to think widely about who we are talking about.

’Integration is totally the wrong word – it makes you think about an organisation and fixes to bits of the system. You also need to remember it is not just about large private sector provision – it is also about the huge number of people, who fund and manage their own care. You have to rethink the boundaries. I would talk about coherence, not integration. Is it coherent for users; is it coherent for carers; and is it coherent for staff? If we achieve those three things we would actually begin to get somewhere.

’If we think that prevention is purely within the world of health and social care, then we will have real problems. The mantra of the new Greater Manchester integration project is about connecting reform and growth. In terms of preventative services, the best single indicator of needing future support from health and care is, if you are over 50 and living in a community where you are more likely to unemployed for the rest of your life. The solution for that cohort of people is not always in the health and social care system, so you have to think more widely. If you think about the biggest single indicator of early death, it is social isolation. There is no drug that the GP can prescribe for social isolation, so you need to think differently and look at the wider strategy.

Policy-makers seem to start with top-down approaches and, as they come to the end of their term in office, they seem to realise it does not work and start to look at a bottom-up approach. This happened with the Labour Government and Total Place, and is now happening with this Government. How do we sustain some momentum and avoid a total reset when a new Government is in place?”

Joe Simpson, Director, The Leadership Centre

‘My passion for health and social care integration comes from it being the right thing to do to provide better joined-up outcomes for people in the system and because it will enable scarce resources to go further. What we have to do is bring health and social care together so that we can build incentives into the system to move it towards using prevention. Unless we can encourage people to take care of themselves, to volunteer and put back into the community, we are just going to keep cutting back.

‘We need to look at models of outcome-based commissioning and population-needs-based commissioning, to use money more effectively in the system, and to reposition the prevention agenda.

‘You have to start with a bottom-up approach. In Croydon recently, 400 older people asked what they wanted from health and social care. They were absolutely clear. They wanted: good information and advice to help them to stay healthy and well to and stay out of the system as long as possible; if they did need care they wanted experienced and skilled professionals that could help them to get back on the road as soon as possible; and once home, they wanted support to enable them to stay in their home as long as possible and to reduce any future interventions. That’s a very clear message for how we should start building services from the bottom up. We need to reclaim the community work skills that have been lost over the years due to short-sighted efficiencies.”

Hannah Miller, consultant and former Executive Director of Adult Services, Health and Housing at Croydon Council

‘The LGA brought together those who have been most ambitious in their plans to integrate health and social care and to pool budgets. They told us that the thing that made the biggest difference was having lay people at the table, and in one case chairing, the meetings. Because managers and professionals couldn’t “misbehave” if there were lay people at the table. The second thing was having all the money available on the table, so that it could not be vetoed afterwards by the finance director. We should, perhaps, take the old Viking approach: swords at the door, money on the table.

‘In most projects the biggest risk can be the boss – including the politicians. How do we manage them? How can they be the leaders? I see some glimmers of hope here. The devolution argument has got much more powerful. The idea that things can be different, and differently led in different places, opens up opportunities that we have not had before. The fact that we have run out of road in terms of austerity in both local authorities and the NHS, means we are prepared to have a different conversation with the public about how we run services in the future.

‘If we combine lay people having a powerful voice, politicians having more discretion to do things differently and a need to renegotiate the deal with the public, it will allow some of the aspirations of the Care Act to really flow through. It will, however, need us to manage that process together.’

Andrew Webster, Associate Director, Local Government Association (LGA)

‘The scales fell away from my eyes when I started working with designers. Designers wouldn’t dream of designing something without going to the potential users and designing it with them.

‘There are lessons for us all to learn about how senior leaders in Greater Manchester have developed partnership working and have overcome the barriers between the “tribes” in the north west.

‘Co-production is about a transfer of power and that’s difficult; there are vested interested that may well resist it.’

Michael Bichard, Chair, Social Care Institute for Excellence (SCIE)

‘It is partly about there being no money, but when there was more money, people weren’t happy with the service they received then either! I kind of dread a world when there would be loads and loads of money because we would be even more “done too”.

‘It’s about where the power lies and how we work together. The principle of personalisation comes from people on the ground using services and wanting control of their own lives. But that idea would never have taken off without working together with professionals in health and social care. It was through disabled people, working with staff in social care, that we could see that personalisation could really work. It really demonstrates how we need to work together.

‘Co-production is a totally different concept than consultation or involvement. We have not made enough of it. It’s about us being involved throughout – right from design to delivery. A lot of us are willing to do things for ourselves. Our families are willing to assist us and to be involved, but what we need from the system is to make this happen. Very practical things can make the difference, for instance not holding a care planning and assessment when the rest of the family can’t turn up. We need to be more flexible so that families can really get involved in playing their part. Not everything has to be done by a service deliverer – there is a lot of self-help out there that needs to be fostered and valued.’

Sue Bott CBE, Deputy Chief Executive Disability Rights UK

‘The reason we are talking about co-production is because there are all these “free resources” out there that do all sorts of things. Because of the services my mother got – to get her up in the morning – she was able to go over to the local school and work with the kids and talk about life about between the wars. It was great for her – it kept her much more independent; it was great for the school, and great for the community more widely. She was a resource. And that’s where we have gone wrong really. We still carry the baggage of the past when we said “Give us your money and we will sort your lives out for you”.

‘We need to move away from this pompous vision of ourselves as the leaders. Power and leadership comes in all sorts of forms. Are we big enough and honest enough to create the environment for those other sorts of power and influence to manifest themselves? We talk about culture change, but we always think it’s others that need to change – not us. Do we as leaders really know if we are contributing to, or impeding the success of our organisations - or not?

‘Good leaders know when to give up their roles and their power. So, for instance, in Greater Manchester, it is chaired by Bury not Manchester, because Manchester stepped back.’

Tony Hunter, Chief Executive, Social Care Institute for Excellence (SCIE)

‘Are we giving people enough experience across the commissioning and provision areas, including across health and social care? Are we drawing on enough experiences throughout the system as we develop the system and shape the market?

‘We also need to draw on the experience of people who use services when we develop products, tools and services.’

Greg Allen, Managing Director, Centre for Workforce Intelligence

‘All of our regional workforce leads are thinking about leadership development. There are fantastic development programmes being run for health, and separate ones for social care, but when we want to work together, we find the money is often kept in silos. For example, we all want occupational therapists – but it is difficult to access funding for OTs to train or undertake CPD in social care or housing.’

Wendy Allen, People and Organisational Development Manager, Thurrock Borough Council

‘The Care Act is well intentioned, but in the current financial climate it risks creating a mismatch between expectations and the resources available. That risks leaving people disappointed. The Care Act stock-takes tell us that most local authorities are reasonably well prepared to implement most of it by 1 April, but there will be gaps. The leadership role should be about setting a culture which accepts it is not all going to be perfect and which accepts learning should take place across the whole system. So, for example, when we make mistakes in Worcestershire, how do we help Nottingham to learn from our mistakes?

‘With regard to prevention, a lot of the activities we are looking for, such as helping someone with shopping, popping in for a cup of tea to see if they are alright – these are things we used to take for granted. But as the state has stepped in to that role, it has all become about funding. We need to get back to a leadership role that is about a strong call to arms. There is a sustained message to civic society about what they can do to help themselves and each other.

‘On integration – there are a lot of good local examples which we need to celebrate. It is about professionals working alongside each other, not about organisational issues. The leadership challenge is about encouraging people to continue to build relationships and about empowering staff and supporting them to work alongside each other.

‘We need to rethink what co-production actually means. We started off with the public sector providing services and expecting people to fit in with what was available. We’ve moved to situation where we commission services. And the way co-production tends to be interpreted is that we set up committees where we invite representatives of services users and the public to sit on those committees.

‘If we are serious about personalisation and about giving people control, the public sector is going to be stepping into a different place. It is going to be a much more individualised relationship between customers and a market of providers. We need a system where the public sector is linking the customer and provider. We need a system

which will allow rapid market entry and exit, as people choosing what they really want. Leaders need to step back, let go of control and accept the risks that will come with that.'

Richard Harling, Director of Adult Services and Health, Worcestershire County Council

Leading the Care Act roundtable

Chair – Lord Michael Bichard, Chair, Social Care Institute for Excellence

Speakers

Baroness Sally Greengross, Crossbench Peer, House of Lords

David Pearson, President, Association of Directors of Adult Social Services

Professor Martin Green, Chief Executive, Care England

Sharon Allen, Chief Executive, Skills for Care and National Skills Academy for Social Care

Guests

Greg	Allen	Managing Director	Centre for Workforce Intelligence
Wendy	Allen	Senior Training Officer	Thurrock Borough Council
Jo	Bibby	Director of Strategy	Health Foundation
Sue	Bott	Deputy Chief Executive	Disability Rights UK
Paul	Breckell	Chief Executive	Action on Hearing Loss
Ash	Chand	Head of Professional Standards	The College of Social Work
Stuart	Etherington	Chief Executive	National Council for Voluntary Organisations
Larry	Gardiner	Member	SCIE Co-production Network
Richard	Harling	Director of Adult Services and Health	Worcestershire County Council
Tony	Hunter	Chief Executive	SCIE
Matt	Langsford	Member	SCIE Co-production Network
Hannah	Miller	Consultant	Freelance consultant
Andrea	Sutcliffe	Chief Inspector of Adult Social Care	Care Quality Commission
Joe	Simpson	Director	The Leadership Centre
Andrew	Webster	Associate Director	Local Government Association

In attendance

Iris Steen, Head of Marketing and Communications

Colm Munday, Care Act Marketing Project Coordinator, SCIE

Leading the Care Act

In early 2015, SCIE arranged a series of roundtable discussions exploring how to improve care and support at a time of growing demand, demographic change and financial constraint.

These sessions covered:

- Community-led care and support
- Leading the Care Act
- Health and wellbeing board (jointly with The King's Fund)
- Social care and technology (jointly with the Department of Health)

This is the report from the discussion on leading the Care Act.

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