



WHAT'S THE FUTURE FOR ADULT SOCIAL CARE?

DEVELOPING A LIBERAL DEMOCRAT VISION
FOR CARE SERVICES

CONTENTS

- 6 Prevention is better than cure in social care as well as health
Baroness Joan Walmsley
 - 8 Social care – the role of the voluntary sector and challenges faced
Councillor Rob Bird
 - 11 Whither care – past, present or future?
John Ransford
 - 14 The challenges of social care in rural areas
Councillor Heather Kidd
 - 16 Social prescribing
Councillor Ron Tindall
 - 18 20 years of caring in rural South Cambridgeshire
Councillor Bridget Smith
 - 21 Breaking down barriers
Councillor Ruth Dombey
- 
- A large, stylized graphic of a leaf or flower, rendered in shades of orange and yellow, occupies the bottom half of the page. The graphic is composed of several overlapping, curved shapes that suggest the veins and edges of a leaf or the petals of a flower. The colors transition from a darker orange at the top to a lighter, almost white yellow at the bottom.

- 24 Putting community before contracts
Councillor Dine Romero

- 28 Getting people out of hospital and back into their homes
Councillor Richard Kemp

- 30 Time to stop the lottery
Councillor Peter Thornton

- 33 Liberal Democrat policy demands for central Government

- 34 Liberal Democrat best practice suggestions for local government

Contributors to this booklet are expressing their personal opinion and are not necessarily the views of the Liberal Democrats or the Local Government Association

INTRODUCTION

If you look at the adverts that sell products and services to people from the third age it would appear that we all live happily, enjoy cruises on the Rhine, spend time in hotels that exclude children and generally indulge ourselves. That is, up to a point, true for some people but is clearly not true for many.

Retirement can be challenging, especially if people are facing a reduction in financial circumstances, are living in a home unsuitable for an older person or have become isolated. The relationship between deprivation, health and social connection is complex but deep, affecting life expectancy. You can also see huge discrepancies in life expectancy from street to street; the difference between two post codes can be just three miles, but 12 years in life expectancy.

We need to recognise that older people can and are making positive contributions to society, given the right environments. Look around your community and see the charity shops, churches and amenity groups largely led by people of that age. Look at who is pushing the children around in the push chairs and you will see a lot of loving people on grandma or grandpa duty. Our society would struggle to cope without the tremendous input of the recently and not so recently retired.

As a society we have failed to think through what has been apparent for at least three decades – that we are living longer but not increasingly healthier.

Even those who are socially engaged, financially comfortable and in relatively good health will reach a point where age-related conditions impact their lives.

In this booklet we try and look at what ageing means as well as how to deal with it. In essence we believe that we as individuals and society as a whole need to be far clearer about how we prepare for our final years. The fact is that we can all do more. The healthier and more positive that we are the more we can stave off and then cope with illness. The more that we have been able to save (and as Liberal Democrats we recognise that not everyone is a position to save) the more options we have for lifestyle choices.

Councils and Government could do much to help us as individuals prepare. We need to make more people aware far earlier of the realities and opportunities of old age. We need to start helping them think through their retirement options much earlier. There is still an appalling lack of knowledge about how much is needed to live decently in retirement and false expectations of the promises of the state pension.

Ideally that thinking will start very early on in life but perhaps more realistically we should make the effort for those over 40.

Structurally, we need to think about where and how people live in relationship to the services they need, their family and their friends. How do we tackle loneliness and food poverty which stretches from the poorest to the wealthiest? How do we encourage more 40-year-olds to eat healthily and exercise more so that they can optimise their retirement years? What is the role of the private sector in helping people work longer if they want to and are capable of so doing?

The good news in this booklet is that there are many solutions to this problem. The better news is that most of the solutions save money and improve lives at the same time.

This is still a relatively rich country. It is not beyond our financial means to ensure that all of our citizens have a good third age. The question is do we have the foresight, the will and the determination to make this happen.

The answer must be yes.



Baroness Judith Jolly

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PREVENTION IS BETTER THAN CURE IN SOCIAL CARE AS WELL AS HEALTH

Baroness Joan Walmsley



When Liberal Democrats talk about prevention we usually think about setting the foundations for good health and preventing 'preventable diseases'. But perhaps we should also be focusing on the role of prevention in stopping a further escalation of the crisis in social care. For years now we have all been aware of the shortfall in funding for social care as well as the NHS. This has resulted in local authorities having to adjust the thresholds for eligibility for care services.

All those who work in or with local authorities know how this has resulted in hundreds of thousands of vulnerable people being left without the care they need. As many local authorities have topped up what they receive from Government in an attempt to serve these local residents, they have now got to the point where they are almost unable to fulfil their statutory duties, let alone any desirable extras.

The sad fact is that, because of the welcome success of the NHS in treating chronic illness and keeping people alive for longer, the demand for support is increasing.

So what is to be done? Of course we must continue to lobby the Government for the necessary funds to enable people to live in dignity. However, that is not the only solution. We also need to reduce the demand for services. Most elderly and vulnerable people would rather remain in their own homes for as long as possible but this often requires home care services. These cost money of course but they are much less costly than a stay in hospital or in a care or nursing home. So better co-ordination between health and care services is essential and progress has been made on this over the past couple of years as local services have taken it into their own hands to overcome the barriers put in place by the fragmentation of services resulting from the 2012 Health and Care Act. Such co-ordination has reduced delayed discharge from hospitals.

However, this is not enough. Other preventive actions can be taken. Local services should be enabled to work together to help people stay well and independent for longer, delaying the need for residential care.

GPs, district nurses and pharmacists all have a role to play and some practices are showing the way, for example GPs visiting care homes to help prevent hospital admissions.

District nurses providing care at home and pharmacists doing regular prescription reviews all have a role to play. Community prescribing has been very successful in some practices, providing access to local activities which keep people active and prevent loneliness.

All GPs should be encouraged to make use of this. Most not-for-profit local services would be only too happy to co-operate.

So where does local government come into this picture? Of course many of the services that help people to stay well, lose weight, take part in physical activity, reverse an addiction, feel part of their community are run by local authorities. But many of these services have had to be cut in recent years. Liberal Democrats should be demanding the resources to allow local communities to care for their older and vulnerable people in a way that benefits them and saves money and a future crisis.

Baroness Joan Walmsley is a member of the Liberal Democrat House of Lords Health Team

SOCIAL CARE –THE ROLE OF THE VOLUNTARY SECTOR AND CHALLENGES FACED

Councillor Rob Bird



The role of volunteers

Charities and other community based organisations have a long-established role in providing vital social care services. Historically, these organisations were generously funded through philanthropy and public subscription. They were largely embedded within local communities and depended heavily on volunteers.

Volunteers continue to play a vital role in social care. They are often the motivating force within charities and community groups. They bring a vital diversity to the sector, often willingly responding to emerging and more complex needs. For many organisations they provide the bulk of their front-line services. Other entities with large numbers of paid staff still rely heavily on volunteers for front-line services and support as well as for crucial fund raising. However, the contribution of volunteers can be taken for granted or may be under-valued.

Assessing the benefits of social care is frequently subjective and cannot always be judged instantly.

Volunteers are becoming increasingly difficult to recruit and retain. Time has become more precious for working-age people who cannot be tied in to regular commitments often needed within social care.

People are retiring at a later age and increasing numbers of retirees are having to care for members of their own family, both young and old. For many social care providers, volunteers are a scarce but invaluable resource.

Funding pressures

Charities and community organisations provide many statutory social care services. Many of these organisations are thus critically dependent on the public purse for their core funding needs. In recent years the unrelenting squeeze on public sector finances has put serious strain on this relationship as commissioners have progressively sought more for less and grant funding has been reduced.

The organisations delivering social care services vary enormously in size and scope ranging from large national bodies to small, highly specialised charities run by just a handful of volunteers.

Some of the biggest care providers, for instance Macmillan Cancer Support, are single entities which operate through a branch network across the country.

However, many of the large national organisations are in fact networks of local entities.

For example, there are around 300 separate charities within Citizens Advice in England and Wales¹, over 150 independent units within Age UK² in England and Wales and 135 separate charities within the Mind organisation.³

Arguably, multi-entity structures enable these organisations to be more closely embedded within local communities and make it easier for them to establish relationships with other agencies operating locally.

However, it can put the sustainability of the individual entities at risk, particularly when funding and other resources are under pressure. There has been some evidence of consolidation in recent years, albeit reluctantly in places. This is expected to continue.

Some organisations have relatively strong finances, being well supported by endowments and donations; some are heavily dependent on public sector commissioning and grants; others survive on a meagre income but nonetheless provide vital specialist services.

Volunteers do not come without costs. Just like a paid staff, volunteers need management, support and training, in order to ensure that professional standards are maintained and improved.

For all but the smallest charities these costs can be considerable and they have to be budgeted for alongside premises, equipment and other running costs.

My experience is that many people do not fully appreciate the costs involved in volunteering. Alternatively, they assume that charities find fundraising easy or they are being financed by other public agencies. For instance, it is often wrongly assumed that Citizens Advice receives substantial Government funding. Elsewhere, GPs often refer people to Cruse for bereavement counselling, not appreciating that they are unsustainable without financial support from the clinical commissioning groups (CCGs). Volunteer organisations often feel that they are being taken for granted.

1 www.citizensadvice.org.uk/Global/CitizensAdvice/citizens%20advice%20annual%20report.pdf see page 7

2 www.ageuk.org.uk/globalassets/age-uk/documents/annual-reports-and-reviews/annual_review_2016_2017.pdf See page 2

3 www.mind.org.uk/about-us/what-we-do/

Commissioning and grants

Funding pressures on local authorities and NHS trusts have forced them to seek improved value for money whenever they outsource services. Contracts are recommissioned on a regular basis with grant funding becoming the exception, rather than the norm.

Charities have had to become increasingly adept at bid-writing and presentations as well as providing regular monitoring reports for commissioners.

This is recognised by many organisations as good governance and helps to maintain and improve service standards. But it has become an increasingly heavy burden for smaller charities and community groups which do not have the resources to compete with the bigger organisations. Furthermore, they can become increasingly dependent on a few key staff.

Public sector commissioners also can find it easier to deal with larger organisations rather than large numbers of smaller entities. These 'partner' organisations may then in turn commission or provide grants to the smaller volunteer groups which operate in specific localities or provide specialist care services for people with the most complex needs. This arrangement can work well but there is a risk of the smaller specialist service providers not getting the funding which is critical to their survival.

Conclusions

Volunteers have a crucial role to play in the provision of social care and are a precious and increasingly scarce resource. Their contribution is sometimes difficult to evaluate and is often under-appreciated. Equally, there are costs associated with volunteer staff which should not be underestimated.

Some charities and community organisations are well supported by endowments and donations but most social care providers are heavily dependent on public sector funding. In turn, the public sector is looking for increased value for money through competitive tendering and commissioning. This is particularly challenging for smaller entities which do not have the resources to compete with major organisations.

Social care is a difficult environment for all organisations with pressures on staffing and funding. The contribution of volunteers is therefore vital. Without volunteers, the social care sector would be much poorer and many services would be lost.

Councillor Rob Bird is a councillor for Kent County Council.

WHITHER CARE – PAST, PRESENT AND FUTURE?

John Ransford



It is a salutary thought, for me at least, to reflect on how long I have been involved in what is now generally termed social care.

I started as a volunteer in care homes and community settings in the mid-sixties, trained as a social worker in the early seventies, then practised in a variety of settings, managed large care organisations for local councils, undertook national policy formulation for two decades and am now a Board Director of two national care provider companies. Significantly, I have never been a service user in any of these roles.

So I have reflected frequently on what it might be like to be dependent on the services I have provided. The answer has often been far from reassuring. For instance, I have only recently found a home for older people where I could comfortably live – and that is as I commence my eighth decade. When I started, the spirit of the Poor Law was still prevalent; if people in need were very fortunate services were provided for them, but there was no room for complaint.

This was gradually replaced by service provision planned with them, through consultation, albeit often through families.

However, the effect in practise is limited so that the statutory right to choice is very much on a 'set menu', rather than a genuine 'a la carte' basis.

This is not to dismiss current, or indeed historic, service provision out of hand. This is a people centred service and generations of carers have done their best and given of themselves, often with very limited resources. Whereas National Health Service spending has been protected and, until recently, has been supplemented for demographic growth, spending on social care has fallen in recent years as it is commissioned predominantly by local councils. 90 per cent of this care is provided in the community, yet 90 per cent of available resources are committed to the acute hospital sector. Amongst other priorities, it is essential to invest in preventing hospital admissions in the first place and improving the quantity and quality of community based support.

Nobody wants to dwell in hospital unnecessarily – certainly not me. Inpatient facilities are fine for treatment and repair, and in most cases we receive a truly world class service. The issue is that our needs are holistic – personal, social and individual.

We may have a disability, long term illness or have difficulties associated with ageing, but we should be entitled still to a decent quality of life. Our challenge is not the creation and maintenance of efficient human warehouses, but the prominence of living environments in which real choice, variety of experience and inspirational challenge can become the norm.

If we are to achieve this, hopefully in my lifetime, there are three challenges we must overcome as a society.

First, all service responses must be created around the genuine needs and wishes of the individuals concerned. This is so easy to state, yet so difficult to deliver. Modern preoccupations with safety, safeguarding and protection are essential, but they must be proportionate.

There are risks associated with daily living for all of us, so it follows that there are risks for dependent people too. These problems must be managed effectively and deftly but any attempt at elimination of risk so demeans daily living that it is no longer worthwhile.

So truly caring staff should enable not direct, assist rather than take over and interact socially with people at all times. Yes, this is time consuming, but rewarding for all concerned.

Helping people to be active prevents unnecessary deterioration and is certainly more welcome. It is essentially about valuing and respecting other human beings, ensuring that life is made up of interactions and partnerships, rather than patronising power relationships.

The principles are the same wherever a person is located; in their own homes, assisted living or residential care. We **must** build service responses around the needs and wishes of the individual, not shoe horn them into a pre-existing service pattern.

Second, we must appreciate the level of public resource needed to fund sufficient facilities of acceptable quality available at the point of need when they are required. As a society we simply cannot maintain the status quo; there is no scope for growth and flexibility of services when the extent of need for older people alone is rising significantly every year. The demographic evidence is there for all to see.

Appropriate values, attitudes and effective practices can contribute to sustainability, but ultimately we must face this as a nation, or a crisis will surely come. We must actively consider a hypothecated national tax, dedicated national insurance or something like it, to tackle such a huge problem.

After all, the precedent has been set with a hypothecated council tax precept for care.

Third, all of us, but my generation in particular, must face a fair allocation of financial responsibilities between individuals and the state.

The notion of social care being made free at the point of need was recommended by a Royal Commission 20 years ago, but was never likely to be affordable in England. So the disparity with services provided by the NHS remains, but there is no sign of any political party upsetting that.

It is my conviction that we must rid ourselves of the mind set that accumulated wealth is primarily intended for inheritance. A great deal of this wealth has been created by inflation, not creative effort, particularly in property. There must be fair and transparent limits on contributions, but entitlement is about responsibility and our means are very relevant to that balance.

I am not afraid of old age or infirmity, but I do want dignity and the ability to make meaningful choices for as long as I am able. I believe that most people want this too. The challenge is to create a care system which is responsive to our wishes and needs, with sustainable funding and transparent responsibilities. With commitment and vision, this is in our grasp.

John Ransford CBE is a Board Director of HC-One Limited

THE CHALLENGES OF SOCIAL CARE IN RURAL AREAS

Councillor Heather Kidd



Social care in very rural areas has a number of challenges. These can include:

- Large distances between clients for carers. Time pressures are therefore added to in travel time. Distances also mean that care delivery costs more in fuel. In a time where we are encouraging people to be cared for at home this stretches already stretched budgets.
- Social isolation can be a huge problem for many older and vulnerable people in both urban and rural areas. Increasingly people are retiring to the countryside for an improved, relaxed lifestyle. As the years tick by that improvement loses its benefits as public transport is limited and access to other services like doctors, chemists, hospitals, socialisation, shopping and much more becomes more difficult.
- Personalised budgets have meant that the group mini bus going around hamlets picking people up often no longer exists and the travel part of their budget is quickly eaten up in taxi fares. These are frequently high as the taxi travels long distances to pick up its client. That also means that the day centre or drop-in centre closes as less people can afford to get there on a regular basis.
- Housing for carers and homes adapted for the disabled and elderly is often only available in towns miles from the communities the carers work in or where people needing care have their family or friends, support.
- Many older people in rural areas are off the gas grid and live in poorly insulated older housing. They often have solid fuel or electric heating. Fuel poverty can add to the difficulties of keeping people healthy.
- The poor mobile signal and broadband in rural areas can also mean that new carers find using their satnav can be very difficult and even phoning to find the address is very difficult if not impossible.
- Broadband and mobile quality also reduces the ability to use telecare to deliver services and also valuable contact via Skype or other face to face digital communication methods.

It is rare that a holistic view is taken of social care delivery which brings together housing, social care, health workers, planners and the targeting of fuel efficiency measures for rural delivery.

The fire service often collects much of the data for some of these areas but more could be done. Integrated teams will save resources, improve health and be more preventative. The voluntary sector can be very good at this. But above all local authorities and local health services need to work hard to 'rural proof' their care policies.

Councillor Heather Kidd is a member of Shropshire Council and the Chair of the LGA Liberal Democrat Group

SOCIAL PRESCRIBING

Councillor Ron Tindall



Social prescribing is becoming the commonly used description for initiatives developed to enable GPs and other primary care professionals to refer patients and service users to non-clinical, local, and community services. However, other names such as Community Referral may continue. It is now being incorporated into NHS Sustainability and Transformation Plans (STP) as decreed by Simon Stevens, NHS England Chief Executive:

“We will work collaboratively with the voluntary sector and primary care to design a common approach to self-care and social prescribing, including how to make it systematic and equitable”⁴

‘Enabling people to benefit from non-medical activities that enhance wellbeing and health’ is not new. The voluntary sector has for many years provided activities and services which have complimented the NHS but it is

only recently that senior managers in the NHS have recognised the valuable contribution that such non-medical activities can make to the overall health and wellbeing of the country.

We should thank the early pioneers who believed in the concept of ‘self-care’, or ‘social prescribing’ as it has become known, two of which were the Bromley by Bow Centre in East London and the Self-Care Forum in Kingston-Upon-Thames. Now with the NHS redirection, social prescribing has become a key factor of the Sustainable and Transformation Partnerships, and it has been estimated that, once accepted and functioning, referral to non-medical services and activities could save 20 per cent of GP time.

Records show that often, visits to the doctor are motivated as much by non-medical reasons as an ailment which can be medically treated. Particularly where no personal or family support network exists, visits to the GP can be triggered by debt, employment or housing issues, or social isolation. Case studies exist which report life changing outcomes but there is a lack of research so far on the impact on healthcare use. A recent NHS review suggests that while evidence is building, social prescribing schemes should be based on principles of good practice.

Taking social isolation as an example, in addition to being bad for the individual, it is also costly for society.

⁴ p45, www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

Talking, laughing, sharing and forming relationships can help to end loneliness. Well conducted studies have looked at the cost effectiveness of interventions to address aspects of loneliness. Coffee mornings in local pubs, knit and natter groups and befriending schemes all help isolated individuals to reconnect with the local community. At the other end of the scale, advice centres can relieve stress and anxiety over more complicated and litigious issues.

To successfully implement social prescribing, health services need to be able to refer patients with social, emotional or practical needs to a range of local, non-clinical services. Depending on needs, this can involve putting people in contact with services that help meet non-medical issues linked to the wider determinants of health. It can also include referrals to a wide range of community based assets, categorised by the Kings Fund to include befriending, volunteering, group learning, arts groups, healthy eating, and physical activity.

Throughout the country, Sustainability and Transformation Partnerships (STPs) are now discussing how to bring together the concept of social prescribing with the reality of developing a delivery system which should have an easy to use and understandable referral process, provided by link workers and/or a central telephone point supported by modern IT access.

As defined by the World Health Organisation, health is a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity. This is very relevant in today's world where often upwards of 20 per cent of visits to the GP Surgery are attributed to concerns other than 'disease or infirmity'.

Further reading

Making Sense of Social Prescribing, University of Westminster

Making the Economic Case for Investing in Actions to Prevent and/or Tackle Loneliness, London School of Economics, Personal Social Services Research Unit

Councillor Ron Tindall is a Hertfordshire County and Dacorum Borough Councillor

20 YEARS OF CARING IN RURAL SOUTH CAMBRIDGESHIRE

Councillor Bridget Smith



Twenty years ago my six year old child became ill and I became a carer over-night. Since then my now adult offspring has learnt to care for himself, but I continued to care initially for my now deceased father who suffered from Alzheimer's and am currently caring for my elderly mother.

When my son became ill there was good medical care as well as support from national charities but little local support and I was very isolated. My son received Disability Living Allowance (DLA) (I recall the 40 page forms with dread) and I received carers' allowance. There was no way that I could return to my previous career in teaching because of the nature of his illness so I resorted to more flexible voluntary work for the next 10 years.

Since it appeared that my son was 'the only child in the village' with a serious medical condition I advertised in the local magazine for anyone else with a child with special needs of any type who would like to meet up.

This brought a number of people out of the woodwork and with the help of a small start up grant we set up a Carers' Support and Information Network Group. This allowed us to hire a room in a community building and to buy tea and coffee.

At that time the county council employed specialist officers to support carers and to provide occasional pots of money. At one time they even took over the running of the monthly meetings, providing lunch and speakers. For a number of years I continued to get small grants to run 'pamper days' for carers with people coming in to give massages, hairdressing, and manicures. The value of these simple and cheap events was enormous with women often in tears that someone was doing something just for them.

In those days, because I was in receipt of carers' allowance, I was able to access free Open University courses so I took one in Writing for Publication and I now have two books in print.

However, austerity has meant that all of that is long gone. The carers, support workers, the grants, the outreach charity support. Councils now commission support for carers but the brief is narrow and the budgets very small.

My little carers group has kept going, meeting every month in my kitchen now that we have no funding and with me providing the refreshments and the members providing cake when they can.

The 'children' we care for are grown up but most are not as lucky as I am in having a child who has been able to take control of his own life.

These are women whose children never grow up, whose children just get bigger and more challenging and whose future becomes ever more of a worry as they age.

These women, some of whom have given up everything to care single handedly for children with life limiting conditions, who cannot work because their charges need 24/7 care, are seeing their benefits capped in order to 'encourage them back into work', the budgets for home adaptations axed, the bureaucracy they have to battle through and the uncertainty over the future of their funding increased. One lady tells me that she cries every day and understands how people in her position feel they can't go on.

These women receive PIP (Personal Independent Payment) but having control of your own budget does not mean that you can buy what you need.

There is a terrible shortage of respite opportunities, be it from people who will take children into their own home to organisations offering more specialist overnight care.

Schooling is poor and patchy. Mainstreaming children with special needs has failed many. Instead of increasing children's opportunities it creates environments where they face failure on a daily basis.

Mainstream teachers are generalist – they cannot be experts in the enormously wide variety of special educational and medical needs our children present with. I had to remove my own child from state education as he was quite simply not safe.

Carers save this country huge amounts of money and yet this government makes them feel like scroungers. Access to educational, medical and social support is patchy and unreliable. Social workers come and go like the seasons. Carers have to fight for everything, be it transport to school, a wheelchair, a medical referral, or one day of respite a month.

What can we do which won't cost millions of pounds to improve the quality of life for carers whilst still allowing them to care for the people they love? We can create opportunities for carers to access educational and learning opportunities at home.

This could be purely for their own pleasure or for personal development with a view to creating opportunities for carers to be economically active from home whilst continuing to care. We need to provide a support and advisory service to carers to identify ways in which they can work and care from home and not just punish them by cutting their benefits and forcing them into poverty.

The biggest need is for good quality respite care. A couple of days off a month can make the difference between an unbearable and a bearable existence. Carers give their lives for the people they care for and their reward is too often being required to give more and more.

We have to ensure that as well as giving people budgets to buy their own care that the care is there to be bought. One of my carers has a child who is so difficult to deal with that nowhere will take him – even for one night. It is she who I most fear for when exhaustion and lack of hope finally tip her over the edge.

Councillor Bridget Smith is leader of the Liberal Democrat Group at South Cambridgeshire District Council

BREAKING DOWN BARRIERS

Councillor Ruth Dombey



“We are not tinkers who merely patch and mend what is broken ... we must be watchmen, guardians of the life and the health of our generation, so that stronger and more able generations may come after...”

Dr Elizabeth Blackwell (1821-1910), the first woman doctor

Dr Blackwell was ahead of her time. She knew that patching and mending has a role to play in keeping people healthy – but only a limited one. She believed that the ability to lead a healthy life goes far beyond that.

Our beloved NHS tends to the sick and provides wonderful care for those who are already ill. But it can do very little to stop people getting sick in the first place. That’s because the causes of ill health – physical and mental – are far more to do with housing, education, the environment and the air we breathe, employment, income and the communities we live in.

As austerity tightens its grip and funding continues to shrink across the public sector, it is becoming increasingly clear that we need radical and far-reaching solutions to the problems facing us. Carrying on as before just won’t do.

Health inequalities are on the increase and the gap in life expectancy is widening between the more affluent and more deprived people in our communities.

We need to break down the barriers between the NHS and local government and work together to properly integrate health and social care.

The solution is within our grasp - and lies in the Health and Wellbeing Boards’ (HWBs) capacity to pool budgets, break down silo working and find local solutions to local problems. In our centralised society with central Government and a centralised NHS imposing top-down targets and one-size-fits-all solutions, the local Health and Wellbeing Boards provide an opportunity for the leaders of place to come up with innovative responses that work for local people.

The power of place is fundamental to the change we need. While Primary Care Trusts (PCTs), STPs and Accountable Care Systems (ACSs) come and go, the leaders of place are the local councillors and the local GPs who stay put and understand their local communities.

We know that the short-term solutions and quick fixes so beloved of national government won't work. We're in it for the long haul.

Only local councils, working closely with local GPs, hospital trusts, mental health trusts, community services, dentists, pharmacists and allied health professionals can bring together all the services which are paramount to good health.

Increasingly the role of local government is to enable and facilitate the conversations and working relationships that bring together all the pieces of the jigsaw of our complicated lives and offer solutions to help people living in our communities lead healthier and happier lives.

It's by no means simple. Historic relationships, financial challenges and the complexity of the different organisations involved all create their own special problems. But these problems can be overcome with a strong common purpose, a shared and agreed vision for the future, a willing partnership and the courage not to default to the defence of our own organisations.

There are many obstacles to overcome – financial pressures, an adequate and properly trained workforce, data sharing, access to estate; the list is endless. But the prize is huge and the benefits will be far reaching.

A radical transformation of the health and care system with prevention and early intervention at the heart of everything we do will, at long last, provide for those stronger and more able future generations that Dr. Blackwell spoke of.

Increasingly in Sutton we are appointing people employed jointly by the council and the CCG to commission important services like mental health and carers.

The decision by Sutton Council to fund four Admiral Nurses to give support to people living with dementia and their families was supported by the local CCG who recognise the value of providing extra support to these families. And the way in which care and health services are provided to people living in care homes in Sutton has been transformed – leading to a fall in A&E admissions and shorter hospital stays for some of the frailest people living in our borough.

While we continue to provide good care to those in need, we are increasingly focusing on prevention and early intervention. Public health, good community based health services and easy access to primary care are all key – and can give people the tools they need to stay healthier longer. Healthy lives mean better lives for the people concerned and the communities they live in.

But that means investing in prevention, enabling the voluntary sector to play a leading role in health choices and health outcomes and having the courage to try out new solutions.

In Sutton we have a vision to break down the silo working within the public sector. We want to stop working within the confines of our different service areas.

We already have fire officers visiting people suffering from social isolation and encouraging them to become more active in their communities. We have police officers running courses on hate crime to raise awareness of physical and mental disabilities and how to better combat discrimination. Our social workers are locality based and are working with people in their families and their local communities, rather than as isolated individuals.

There is still a long way to go. Central Government and the NHS need to let go, recognise that their top-down diktats don't work and trust local government to come up with solutions.

But our Health and Wellbeing Boards could already be doing so much more. Sharing ideas, trying out new ways of working, challenging ourselves to be more ambitious and more innovative.

"We are not tinkers who merely patch and mend". We are the leaders of our place, accountable to our local communities and determined to improve the health and wellbeing of the people living in our area. The solution is within our reach - if we have the courage to grasp it.

Councillor Ruth Dombey is the Leader of the Council at the London Borough of Sutton

PUTTING COMMUNITY BEFORE CONTRACTS

Councillor Dine Romero



Bath and North-East Somerset Council (BANES) has been a frontrunner in the area of health and social care integration.

In 2011, the then Liberal Democrat run council and NHS supported a proposal for joined up services. A Community Interest Company (CIC), Sirona, was formed to provide publicly funded health and social care services.

As the initial contract ended, a further review followed between January 2015 and March 2017 on how best to provide a wrap-around service that picks up the needs of vulnerable people who are in need of care. The proposal was to enable budgets and services to be tailored to the needs of each individual as well as each person being able to have an active choice into the type of care that they receive.

In April 2017, Virgin Care was awarded the 'prime provider' contract for delivery of community health and care services.

Virgin directly provides some services but also commissions other organisations – including NHS, social enterprise and voluntary sector – to deliver services.

Liberal Democrats and residents have concerns over the award of this contract to a private company rather than the local CIC and how it has been working out.

Part of the reason for the awarding of this contract was the promise of excellent IT provision, but there have been some problems in this area; more recently there have been concerns around managers seeking to discourage whistle-blowing to the Care Quality Commission.

Beyond the Virgin contract, there are support services that are not commissioned by the council but which do answer needs identified by schools, police, the community and indeed the council.

For example, many children at schools in the most deprived wards in Bath were arriving at school hungry. I saw this for myself at lunchtime when children would forgo play in favour of second and third helpings of lunch. A simple breakfast club was set up through a partnership of local churches.

This scheme isn't run from a school but from an ex-youth centre on the way to the local primary school, but has the added advantage of getting more kids into school on time, and there have been improvements in attainment.

This same partnership of churches also funds a step-down program from our Troubled Families intervention work. This program provides a lower level of support to help reduce dependency on professional help.

Council funding from Government has reduced significantly over the few years. We are told that by 2020 we will no longer receive this funding. At the same time demands on councils' budgets are increasing, especially from social care. Bath and North-East Somerset Council will spend 80 per cent of all council funding on care.

Councils are in turn putting pressure on those that have already stepped up to help. In my authority this means that the same church organisations mentioned earlier are now also being asked to run and maintain our youth centre buildings, so that youth services can still be run in the areas of greatest need.

There are many, many more demands being placed on similar organisations, and on bands of volunteers, as council services are reduced. Councils are becoming even more reliant on volunteers to make up the shortfall in provision.

But the obvious concern here is what happens when the money dries up for the supporting partners, and/or the volunteers stop volunteering?

In an age of growing populations, with the young saddled with debt and worries over regular income in an increasingly gig-based economy, the elderly are left more isolated while the middle-aged are sandwiched with the burden of caring for both young and old, and probably juggling full time work as well; who has the time to devote to volunteering activities?

Our society and our communities are becoming more and more disconnected by class, income, Brexit, family dispersal, and access to services.

Elderly people are fearful of the closure of libraries, pubs, banks and post offices because this may be a rare opportunity to have a real conversation. We hear that many doctor's appointments are a cry for help from lonely people and not directly for medical treatment.

Loneliness⁵ affects nine million people in the UK and costs the NHS £32 million a year, and has been shown to have a negative impact on people's health and wellbeing.

5 www.edenprojectcommunities.com/the-cost-of-disconnected-communities

This issue has been considered by Bristol-based housing charity St Monica's Trust, perhaps nationally best known for its residents', Mary and Marina, appearances on Gogglebox.

The trust took part in a televised experiment 'The Old People's Home For 4 Year Olds'.

Residents and pre-school children were selected to test the latest research from America on whether intergenerational interaction could improve the lives of the older volunteers. Over the course of six weeks the older group's physical and mental wellbeing was found to improve. The children also enjoyed the experiment, learnt a lot, and planned to stay in touch with 'their old person'.

There are plans to replicate this experiment between a new primary school and the latest of St Monica Trust's care homes both on the Cadbury's site in Keynsham, in Bath and North East Somerset.

There are, of course, more traditional support schemes, funded by councils, by housing associations, churches and by charities. For example, in my own ward of Southdown, the local Methodist church puts on a cooked lunch every Thursday for elderly residents, most who live in nearby sheltered housing but without a warden onsite anymore.

Previously wardens would arrange regular social events as well as be on

call for problems and emergencies. Cuts to registered social landlord grants have meant that the social part of the service went several years ago, so once again a local church has stepped in. Without such services, elderly people are at risk of isolation; many are no longer engaging in the community, and often are not even leaving the house.

Local choirs including one for just this group of residents have been started. Goldies, a singing group set up in Southdown, which has proved to be so popular that there are now several more groups across the South West stretching even into Wales.

Residents really look forward to these sessions. And there is some evidence that taking part has a positive effect on people with dementia, as well as on loneliness.

The main problem with such ad hoc provision is that it is not reliable and is often dependent on a small core of volunteers. To illustrate this point, I would like to draw attention to the friendship clubs within Bath and North-East Somerset, aimed, on the whole, at older people. These, like the other schemes mentioned, go some of the way to filling the growing void but these schemes are vulnerable.

Not least as they are often run by the elderly for the elderly. The time that the lead players can give is variable. Recently the local paper ran a campaign

as the event organiser of the Oldfield Park Friendly Club couldn't carry on. She was worried that unless a replacement could be found the group would be forced to close.

Luckily the campaign was successful. This time.

In conclusion, it is becoming clearer that small local schemes are good at adding value but should not be a replacement for a properly funded social care system. The questions remain: who should pay for it and who should provide it? Is it the responsibility of the council?

In order to do so successfully, and in line with current government policy, councils are being driven into becoming social enterprises having to create new income streams to make money, which is then spent on social needs.

The local authority needs to have a high level of income from business rates retention, investments (such as commercial property to let out) to provide income streams, or tourism. Restricted budgets, coupled with high levels of care need, an ageing population and growing numbers of people with complex needs, mean that councils struggle to balance the books and maintain funding for other local services.

Giving councils the ability to raise an extra six per cent through council tax

doesn't make enough of a difference, no matter how the percentages are divided up over the three years.

In most cases local authorities remain the best placed bodies to make sure that all services are properly joined up, work around the individual and avoid duplication. But they need to be properly funded.

The Government has a duty to find a solution which will properly fund a health system which includes social care. I believe that the Liberal Democrat proposal of raising this through a one percent increase in taxation is the only sustainable and fair way of doing this. The tax mechanism is less important than getting the money to local authorities to use. It cannot be a means tested grant that needs to be applied for by individuals. Until the Government faces up to the care funding crisis, local councils will have no choice but to spend every penny on social care, with nothing left for any other council services, such as libraries, bin collections or potholes. The Government must understand how important this is and must accept this responsibility.

Councillor Dine Romero is the Leader of the Liberal Democrat Group, Bath and North East Somerset Council

GETTING PEOPLE OUT OF HOSPITAL AND BACK INTO THEIR HOMES

Councillor Richard Kemp



Hospitals are not a good place for people of any age to be if they no longer have a condition which needs major clinical or medical intervention.

For older people, in particular, it places them at two types of risk:

- firstly, hospitals are dangerous places – they are full of people who are ill, many of them with infectious diseases which are difficult to cope with
- secondly, there are real problems with lying in bed for too long - elderly people in particular quickly lose muscle tone and bone mass and it is said that two weeks lying in bed can age the muscular/skeletal system by two years.

Just as important is the loss of morale faced by people who are stuck in a hospital bed.

They want to be at home where they feel more comfortable and where their family and friends, often ageing themselves, can access them more rapidly.

In Liverpool the council has developed two hubs in the north and south of the city which help people leave hospital and re-educate themselves.

Many of the people who use these have little or no family or friend support mechanisms to help the often difficult process of moving from a long-term hospital stay to self-reliance in their own home.

The work of the Granby Hub in Liverpool

I have visited my local unit twice and have been very impressed with what I have seen. In the case of the Granby Hub the building was originally built as a long term residential home and needed little adaptation for a new role. It is bright, light and airy and filled with compassionate staff. The centre is split into small residential units of about eight people so that there is a strong element of a family feel to the units. Medical help is provided by a close working relationship with a local GP practice who liaise both with the hospital and the person's usual GP.

Perhaps the biggest practical assistance is given by professional occupational therapy (OT) staff. Many of these people need help with learning again to climb stairs; to walk carefully; to use the simple tools which are necessary to help them live independently. The OT staff learn what the needs of the individual are and work to ensure that necessary adaptations and aids are provided in their own home.

Wherever possible people are both encouraged and helped to do the most they can to assist with the unit's running and do things for themselves.

For many of the people who come in this is the first time that have really been cared for outside their own home. People are apprehensive as they meet people from a wider cross section of the community than they might have done before. This is particularly enhanced because of its location. It's great for buses from most of South Liverpool but Granby is considered by some to be a bit of a rough area. This perception is not justified and is quickly dispelled when people actually get there.

This is not a long-term care home. Most people will leave the centre by the end of six weeks. Almost all of them go home with follow up services sorted out but for a few the journey is a long-term residential home following a detailed assessment.

Demand for the services of this unit is high. They have an average 97 per cent occupancy rate. This level of demand means that some people who could really benefit from this service cannot be helped.

The good news for the sector is that this model is good for the individual but very good for our finances. In crude terms a week at the centre costs the same as a night in a hospital. This does not include the health service costs provided within the centre. It is still, however, a hefty saving. With all costs factored in, a week at the centre costs the same as two days in a hospital bed.

This centre passed the 'my mum' test. My mum is dead now but I always ask the question, "Would I have been happy for my mum to come here?" The Granby Hub passed this test with flying colours.

Councillor Richard Kemp CBE is the Leader of Liverpool Liberal Democrats and the Liberal Democrats spokesperson on Health and Social Care at the LGA

TIME TO STOP THE LOTTERY

Councillor Peter Thornton



I used to attend business meetings in a small town in the American Mid-West. The locals had a saying: “Jackson isn’t the end of the world, but you can see it from here...”

Those of us who have passed the state retirement age may well have had similar thoughts. You’re not yet at the end of your life, but you can glimpse it from here.

What you see will depend upon what you’ve experienced so far, often with your parents and grandparents. Did they have a good old age? Were they well looked after in their time of need? If they have passed on then how was the end, and the time preceding it?

If your experience has been a positive one then you’ll likely expect to enjoy a good and secure ‘third age’ with the knowledge that you’ll be well cared for when ‘the time comes’.

But if your relatives felt abandoned and forgotten by a system too busy to cope, then you may join the growing band of pensioners who are scared of living

too long and increasingly afraid of their old age. I’ve met far too many health professionals who have mentioned “tickets to Switzerland” when I’ve asked them how they would like to spend their last few years or months. It shouldn’t be like this. It shouldn’t be a lottery.

Old age is not some mysterious state that we don’t understand. We know what needs to be done, and we need to do it better.

There are three things to be addressed:

- 1. Good health in later life is largely determined by how we live our lives before arriving there. Our genetic inheritance does play a big part, but we can’t alter that.**

But for now, we need to be much harder hitting with public health messaging. We must hammer home the ‘big five’: weight; eating (the right things); drinking (in moderation); smoking – don’t; exercise – do.

These are simple messages that should be reinforced at all levels.

Do you remember the AIDS crisis of the 1980s? It wasn’t possible to go about daily life without being bombarded with public health messages. Why aren’t we telling our population that working on these five things are significantly reducing the risk of both cancer and dementia?

We've largely succeeded in getting the message over about smoking; I don't think I've met anyone in the last ten years who wasn't aware of the dangers. How did we do this? Hard hitting advertising at all levels, that's how.

Good public health is a two stage process. Firstly, convince the public of what they need to do to be healthy. Secondly, give them the tools to do it.

I'll end with a question: how much money would the NHS save over the next 80 years if every child was able to cycle safely to school?

2. Good quality, well organised and integrated healthcare.

I'll never forget going to see my 80 year old uncle and him showing me a number of cards spread out on his sideboard, each one for a different appointment. "It's a full time job being old" he said to me. It shouldn't be.

Old age is not an illness and it shouldn't have to dominate the lives of the elderly as much as it does. We need care services to be more joined up as has happened in other sectors. For example, I take my car to the garage and I no longer have to visit the carburettor specialist at one end of the town followed by the auto electrician at the other.

And by the way, they don't seem to have any trouble calling up all the records on the computer.

Motorists expect a modern high class service, but enter the world of health and we are transported to the past and a world where you feel Dr Finlay, the TV doctor from the 1960s, would still feel at home.

It's not rocket science – but it is a science and thankfully the NHS no longer has the luxury of carrying on as it has in the past. It is being forced to reform, just like councils.

3. Money. The majority of health money is spent in later life. Hospital beds and care homes are expensive places to be. We can develop strategies to put them off but there sometimes comes a time when neither can be avoided.

It's time to decide. Do we want a society where the elderly risk dying in squalor and confusion? Or are we prepared to properly fund their care?

Yes, there are hard choices to be made. Efficiencies will only go so far, in the end we need good quality modern buildings well-staffed by people who care and who are adequately rewarded. That costs money, about £32,250 a year in a case of dementia.⁶ The money needs to come from somewhere and throwing around terms such as 'death taxes' and 'dementia tax' doesn't really help does it?

⁶ Source: Alzheimer's UK, www.alzheimers.org.uk/download/downloads/id/2323/dementia_uk_update.pdf

The thing about old age is that we all plan to be there one day. We don't plan to be ill, or homeless, or unemployed, or have mental health challenges, or any other of the many conditions where the state needs to help us.

But we all plan to be old. We all have a stake in making it a place to enjoy, and not a time to endure.

This needs to be a cross-party journey, but the Liberal Democrats should be leading and showing the way. We should be constantly challenging the current practice of bungling in a little more money when the voters notice the queues of ambulances. We need to think differently and we need to act differently. This is why we are politicians – to make things happen.

We're investing money in Cumbria by building three brand new council care homes, replacing several of our homes from the 60s that no longer meet modern standards. Unusually, our council is still in the business of providing care home places for residents and we value our mixed economy in Cumbria.

Our new homes will cater for residents with advanced frailty and dementia, this is the area we find that private provision struggles the most.

The Care Act doesn't make it easy to run our own homes, but we sense that the pendulum is swinging back towards a small amount of local authority provision and we are determined to make it work for the benefit of our residents.

Councillor Peter Thornton is the Cabinet Member for Health and Care Services for Cumbria County Council

LIBERAL DEMOCRAT POLICY DEMANDS FOR CENTRAL GOVERNMENT SHOULD:

1. Establish an independent commission along the lines of the Office for Budget responsibility to provide assessments of current and predicted needs and fact checking government and other types of pronouncements on funding packages.
2. Increase income tax by one per cent, producing approximately £6.2 billion per year, with the entire proceeds of this being hypothecated to health and social care
3. Immediately plug the estimated £1.3 billion funding gap facing providers to stabilise the market and prevent further providers handing back council contracts or ceasing operations altogether.
4. Make further financial settlements with councils to fill the projected gap in social care spending of £2.2 billion by 2020.
5. Introduce a cap on social care expenditure of £85,000 so that families can plan predictably for an unpredictable third age.
6. Allow Accountable Care delivery for health and social care services to be led locally for the third age by democratic local government.
7. Provide a nationwide service of financial advice for the third age to deal with all aspects of financial planning, not just pensions, to help third age citizens avoid scams and trickery.
8. Move to end the health care/ financial care lottery which can result in wealthy people getting all their needs cared for because they have a certain type of need and poorer people losing almost all their savings because they have another type of need.
9. Draw up a comprehensive strategy on social prescribing to deal with the social determinants of health for the elderly including loneliness, lack of physical activity and poor quality and inappropriate food.
10. Finally, for the Government and the Leadership of the Liberal Democrat and Labour parties. Recognising that any long-term review of the needs of the growing number of elderly would be best served by an all-party consensus on a range of issues including funding; health care; social care; and preparations for ageing. We urge the Leaders of the Liberal Democrat, Labour and Conservative parties to come together to achieve the same national consensus which has enabled the NHS to stand the test of time.

LIBERAL DEMOCRAT BEST PRACTICE SUGGESTIONS FOR LOCAL GOVERNMENT

Councils should:

1. Recognise that under the Equalities Act 2010, and as part of representing the broad spectrum of people living in any area, councils must have regard for age related issues in all areas of policy.
2. Adopt a 'whole council' approach to ageing with housing, leisure, transport, education and planning services sharing joint responsibility for preparing for and caring for the third age alongside the adult social care service that must maintain leadership of the council's intervention. The work that we do in our parks and libraries and community centres is good for all people as we get older and will help stave off the feeling of ageing.
3. Ensure the development of third age 'Parliaments' to enable third age citizens to directly express their needs and desires to councils, the NHS, the voluntary sector and the private sector.
4. All activities to be framed around improving the main desired outcome by asking the question – "Why not home, why not today?"
5. Start working with people in their 40s to help them:
 - develop positive health practices which lead to them being healthy at the age of retirement
 - develop financial models to help them through retirement
 - develop a lifestyle which can readily adapt to worklessness.
6. Hold weekly face to face meetings between a small group of leaders (executive level) from across partners to resolve current blockages, particularly in the delayed transfer of care.
7. Embrace new technology. Encourage people to use commercially available equipment such as Fitbits which will enable them to keep an eye on their own health but can also on a regular basis pass information on the health and social care professionals.
8. Develop an online cost-effective market place to enable local providers of care services and products to place them on the internet in such a way that third age people and their carers can contrast and compare them and provide valuable local feedback.
9. Create strategic partnerships with providers of domiciliary and residential care to enable a full understanding of system wide pressures and jointly seek locally determined innovative solutions.



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