



UK Homecare Association Speech

Colleagues

I'd like to begin by thanking Mike and his colleagues at the UK Homecare Association for asking me to speak to you today. The delivery of more and better care at home is among the most urgent priorities in health and social care in Scotland; but it is not without its challenges.

Indeed, it is exactly these challenges that I'd like to discuss today and to ask you to give consideration to potential solutions. I want to speak to you about the value of partnership amidst diminishing public finance; securing best value in commissioning and procurement; and our efforts to reshape older people's care.

Let me start with the reduction in public finance. On the back of the global recession and government intervention to support a crumbling banking sector, levels of public sector borrowing have reached previously unimaginable levels.

The problem with debt, of course, is that it has to be repaid and that has a corresponding impact on levels of public finance.

Councils and NHS partners are already feeling the bite of financial constraint: in local government, we had £174 million less in our coffers than anticipated for 2009/10, and further cuts of £332 million have been assigned to Scotland for 2010/11.

Thereafter, the outlook is even more unsettled. Indeed, the real challenge will come during the next spending cycle: our projections suggest we should be planning for a real terms reduction of 12% in local government budgets. Other commentators are speculating about cuts in the order of a billion pounds to the Scottish block grant in 2011/12. This is uncharted territory and will have a big impact on health and social care services.

That is not to say we are without choices in Scotland. As a nation, we have to decide what sort of health and social care system we want. Scottish Ministers have publicly committed to protecting Health from the worst of the cuts.

Although this position remains ambiguous, COSLA has set its stall against any move which offers the NHS protection at the expense of local government. This is not simply a case of self-interest, nor indeed an attack on our partners in the NHS. The reality is that NHS protection could mean 12% cuts to council budgets become more like 18% over three years. That will further reduce community care capacity, which in turn will lead to an increase in the number of unplanned emergency admissions to hospital and an increase in the number of delayed discharges. So NHS protection isn't just bad for councils. Ironically, it's bad for the NHS as well.

The difficult financial context has also given me cause to raise questions about the long term sustainability of Free Personal Care, a policy that is more fiercely defended than just about any other issue of public concern in Scotland. Let me state quite clearly: I am not against Free Personal Care. But I am keen to establish how it will be paid for into the future given what we know about demographic change and reductions in public finance. We need to ask hard questions about its affordability.

The Sutherland Review in 2008 said that the policy was sustainable for five years – and that was before the financial crisis. We're now hurtling towards 2013 with no clear view about how Free Personal Care will be paid for into the future.

Leaving aside the issue of Free Personal Care, I think we are developing a remarkable degree of consensus around a new vision for health and social care, the seeds of which are already being sown in different parts of the country. The philosophy of care that underpins our vision is well established. I think we all now agree that personalisation will be the cornerstone of public services into the future. The personalisation agenda marks a step-change in the way care and support services are commissioned.

We might describe this process in terms of a move from clienthood to active citizenship, which creates a different role for wider local authority functions and that of partner agencies, which is strongly focussed on community capacity building, including access to universal services for previously marginalised or excluded groups. This leads to a very different relationship between the individual, the

state and, where appropriate, a service provider – in a context that recognises that the gap between assessed need and available resources is likely to grow and that tools such as eligibility criteria and waiting lists are inadequate to meet the scale of the challenge facing us.

Part of this agenda will involve working harder to embed self-directed support as a philosophy of care, whereby individuals are given more control over the choices that are made with respect to meeting their social care needs. This requires people to be aware of the financial value attributed to meeting their needs – known as an individual budget – to allow them to make an informed choice about how it is used to meet their needs. If we are serious about enabling people to exercise choice and control over their lives and a person requires formal services, then they should be able to maximise choice and control over that too. This might take the form of a direct payment, but it might not. A direct payment is simply a mechanism - often a good one, but a mechanism nonetheless. I believe that the philosophy of personalisation demands that social policy is agnostic about the type of support mechanisms that are best for individuals – that should be decided in partnership with

individuals with care needs, following a focused discussion about individual needs and outcomes.

More broadly, I know that the procurement of social care is an issue which has frustrated many of you here today: you highlight the different funding arrangements between in-house and external provision; you highlight the challenge of continually driving down costs; you highlight the 'task and finish' care models that are forced upon providers as a result of commissioning practices. I would like to say in response to these arguments that, yes, local government does need to engage with you on these issues; we need to do a better job of listening to your grievances. But that responsibility cuts two ways – providers need to work with us to ensure that we design a commissioning framework that delivers best value and improves outcomes.

In terms of the future development of your sector, we need to do more to improve the reach of care at home services. The recent SWIA report highlighted that progress has been slow in shifting the balance of care from care homes and hospitals towards supporting people at home. We need to invest both in intensive home care as well as preventive

and early intervention services. The challenge will be to square this circle within the current financial context.

The vigour with which councils are driving forward their reablement programmes can only help to advance the case for care at home. This service innovation offers great potential to achieve better outcomes at lower cost. It normally involves adults referred for domiciliary care receiving around six weeks of intensive support to restore confidence, activity and self-care ability, and hence increase independence. In England the Department of Health has stated that “up to 50% of older people who were offered a short-term package of re-ablement based care did not require further social care support at the end of their treatment. The evidence indicates that this has an impact in delaying a person’s need for further care by over two years”.

At the same time, it should be noted that these efficiencies might only serve to accommodate the additional demands created by the growing number of older people and the increased intensity and complexity of care at home.

On that note, let me turn, finally, to our work on reshaping care. Our strategy is, simply put, to reduce demand for formal health and social care services and optimise the supply. On the demand side, our vision makes certain assumptions about the types of support that will be available to people. It will be focused on keeping more people out of the formal care system by empowering carers, families and communities to develop the support mechanisms that foster greater levels of personal independence for frail older people. It envisages a less atomised society, where our neighbour's health and well-being is *our* concern. It promotes greater levels of personal and community responsibility, and reduces the importance of formal state intervention.

On the supply side, it means addressing every last inefficiency, making public money work harder and last longer, ensuring that partners in the statutory sector collaborate with each other and with providers in the voluntary and private sectors. It means looking at public resource in the round rather than as the property of organisations or service departments. So that is our strategy: reduce demand and optimise supply.

Our methodology rests on detailed analytical work being advanced around different scenarios and projections. For me, this means costing models of care based on anticipated patterns of demand and demographic trends. It means identifying whatever savings, efficiencies and collaborative gains can be made through the partnership agenda. And finally, it requires that we look forensically at our mutual policy commitments and ask questions about their sustainability into the future.

Let me turn finally to our tactics. This will involve open and honest discussion with the public about how best to fund the gap that remains. And let me be honest about this point - there will be a funding gap at the end of this process. Current estimates put that at well over a billion pounds by 2016. Effective reform will certainly close this gap, but it won't make it disappear.

That leaves a political decision for the respective spheres of government in the UK. We might need to ask people to pay more money through taxation. We might need to ask people to pay more out of their own pockets. Or if people

do not want to pay more, we might need to offer them less. The UK Government has promised to establish a Commission to explore these issues – we will watch on with interest as that develops.

That is not to say we cannot form a view about these issues in Scotland. We can ask questions at this time and hour that we might not have been able to ask during better times. And so it is that I think we need to reorder the health and social care agenda, to really engage in profound questions about the role of the state versus the role of the family and community. We need to ask people what they want and how they think it should be paid for.

Thank you.

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