Adult social care

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Introduction

Going into the 2015 election the policy direction of adult social care is the subject of a high degree of political consensus. All mainstream parties agree that, in contrast with NHS clinical services, individuals should contribute to the cost of their social care package unless they have low income or few assets, and that a mixed economy of provision with a substantial role for the private sector will continue. The Care Act 2014 affirmed that support must be preventative rather than crisis-led; once people need care it should be integrated with health services; and care and support should be personalised, so that people have choice and control. Whoever wins the election, this policy direction will continue to shape the experiences of older people, people with disabilities and people with mental health problems. In the sections that follow we consider the progress to date on prevention, integration and personalisation, what is proposed for the future and the likely barriers to success.

Prevention can be harder than cure

There is obvious appeal in preventing people from experiencing deterioration in their physical or mental well-being to the point at which informal social networks can no longer cope and they therefore rely on formal social care services. Not only could preventative services enable people to maintain their autonomy, independence and current quality of life but should make public funding stretch further. This thinking has underpinned recent social care policy as it has numerous whole sector and user-group specific social care policies of the past. These have resulted in a well-developed typology of prevention services that include those that: prevent people from becoming frail, disabled or unwell in the first place (primary); avoid a worsening in people's conditions or social situation or at least slow this process (secondary); and seek to enable people to recover from a crisis or minimise the social impacts of a disability or illness.

The Care Act reflects this typology, and emphasises that all adult social care services should be seeking to 'delay and prevent' care needs in 'every interaction' with individuals and their families, i.e. prevention is not just the responsibility of bespoke services (DH, 2014). Other services provided or overseen by the local authority and its partner agencies are also seen to have a role, with health, housing, leisure and transport sectors seen as important pieces of the prevention jigsaw. Furthermore many if not most mainstream and informal activities that individuals undertake (such as paid or voluntary work, keeping fit and active, maintaining friends and family) are recognised as potentially helping to maintain people's well-being. Local community resources, developed and delivered by the third sector, are often central to the establishment of supportive networks, offering advice on what is available and more innovative approaches.

This whole-system, asset-based, person-centred and locally permissive approach to national preventative policy, has much to commend it. Despite these positives, it is clear that if we see the main outcome of prevention as ensuring that limited public sector budgets will be sufficient for the future then prevention is an endeavour doomed to failure. Demography and advances in medical science dictate that increasing numbers of people will become older and frailer and therefore in need of support, even if this uptake is delayed or minimised for a period of time. Rather than abandon prevention, however, we need instead to be realistic in what can be achieved and celebrate improvements in quality of life and delay in resource usage for individuals and families. We need to be smarter in measuring relevant impacts and sharing learning, and have greater patience over when these can be achieved, to avoid quick fixes being favoured

over those that may make more difference but work over longer timespans.

Stronger together but happier apart? The challenges of integration

Under New Labour, there was a stated commitment to 'joined-up solutions to joined-up problems' and to bringing down the 'Berlin Wall' between health and social care (Hansard, 1997, col. 802). Under the Coalition government from 2010, it seemed initially as if this would be different, with many people fearful that the government's health reforms (eventually embodied in the Health and Social Care Act, 2012) would lead to greater competition and fragmentation. In response, the NHS Future Forum (2011), which was established to review the proposed changes, placed significant emphasis on the need for 'integrated care' – ensuring that the support delivered is joined-up around the needs of the individual and is experienced in a seamless fashion by people using services.

This has since become a key part of the policy rhetoric, with a series of pronouncements and initiatives designed to promote more 'integrated care'. This includes the creation of new Health and Well-being Boards to oversee the integration of services at local level, the creation of a series of 'integrated care pioneer' pilots to test out new ways of working and the establishment of a Better Care Fund to encourage a greater pooling of health and social care resources. The difficulty with such initiatives is two-fold:

• While few would disagree that it makes sense to work together in situations where people have complex or multiple needs, the current health and social care system has not been designed with integrated care in mind. Each agency has different legal powers and responsibilities, accountability structures, budgets, geographical boundaries, cultures, IT systems, and so on – let alone the fact that one service is universal/free at the point of delivery and the other is heavily targeted/means-tested. A famous article on 'the five laws of integration' (Leutz, 1999: 93) argues that 'you can't integrate a square peg into a round hole' – and

yet this is exactly what front-line services are being asked to do.

• The very fragmented nature of the health reforms and the intense financial pressures facing public services (especially local government) means that potential partners are having to navigate a much more complex, congested environment, and are having to try to make time and space to develop local relationships in incredibly stressful and difficult conditions. In one sense, it has never been more important to work together, and yet – ironically – it's never been more difficult.

Going forwards, it seems unlikely that current tinkering around the edges will be sufficient to generate more integrated care. While we have a system based on a rigid distinction between 'health' and 'social care' needs, we can ask local services to try their best to work across such fault lines – but expecting them to genuinely solve such embedded problems would be a triumph of hope over experience.

This time it's personal(isation)

The third impetus for change in adult social care comes from the aspiration to personalise support around the individual. This became a formal policy commitment following the signing of the Putting People First Concordat between the then New Labour Government and the social care sector in 2007 (HM Government, 2007) – although its genesis lies in much older campaigns to increase choice and independence for people with disabilities.

Enhancing choice and control has primarily been achieved through financial devolution, making those people who are eligible for state funding aware of how much money is available and then giving them as much control as possible over how that money is spent. Efforts have also been made to increase people's social capital and enhance their access to universal services and spaces, rather than relying only on bespoke social care services.

Over almost a decade of implementation, there are many powerful stories of people's lives being

transformed through personalisation – of being able to employ their own staff, or to buy in services that enhance their well-being but don't come off a traditional menu of care services (a laptop, a family holiday to Centre Parcs, for example). The perceived success of personal budgets in social care has led to their extension into the NHS for people receiving Continuing Healthcare.

However, the extent to which personalisation has been a success in social care is highly contested. It does not appear to work well for older people (the largest group of adult social care users), where take up of personal budgets is lower than for people with learning disabilities (45% of older people compared to 59% of people with a learning disability (Age UK, 2013)). The difference is particularly stark for direct payments, which are associated with the most transformative outcomes for people: only 7% of older people are in receipt of a direct payment, compared to 25% of people with learning disabilities (Age UK, 2013). The per head care spend for older people tends to be so small that it is difficult to identify creative ways to cut it up differently. Social workers have expressed grave concerns about the problems of overlaying personalisation on top of austerity – with additional bureaucracy and time spent on brokerage or support planning limiting the scope to review and support people once they are in the system. People committed to using personalisation as a way to enhance citizenship rights have clashed with those who appear to see it as an effective lever to dislodge longstanding state responsibilities for welfare support (Needham and Glasby, 2014).

Despite palpable shortcomings in the current approach, it is hard to give up on the aspiration that care and support should be person-centred, and efforts to extend this will continue in the future. Tackling the underlying funding settlement for social care is key to securing a version of personalisation which supports citizenship, overcoming the 'deficit' model of social care in which people are viewed as a bundle of needs rather than of assets. Making it easier for people to access peer support, and meaningful advice and information is also vital.

Conclusion

All of the major parties going into the election are promising to make real progress on the three aspects of adult social care discussed here. There are differences of emphasis in the party proposals but not of broad intent. A casual glance at the 2010 manifestos would indicate that this was also the case. Making the policies happen will require a willingness to rethink the post-1945 welfare settlement more fundamentally so that structures and incentives allow a substantive commitment to preventative, integrated and personalised care. The pots of money that come with system redesigns cannot continue to paper over the cracks of a system which urgently requires adequate public funding. Forthcoming changes such as the introduction of the cap on care spending risk adding to the complexity of the system without bringing in sufficient new money to ensure adequate coverage.

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